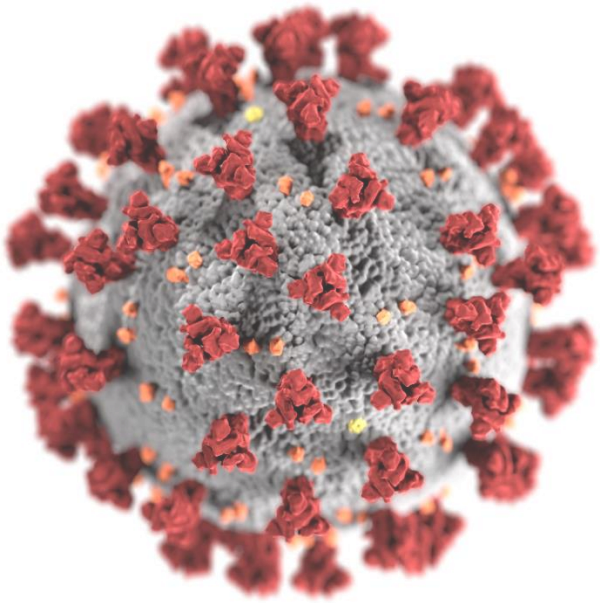
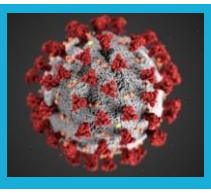


COVID-19 Vaccination Plan

NEW JERSEY

PREPARED BY NEW JERSEY DEPARTMENT OF HEALTH
OCTOBER 16, 2020 | VERSION 1

NEW JERSEY
INTERIM COVID-19 VACCINATION PLAN



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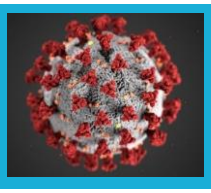
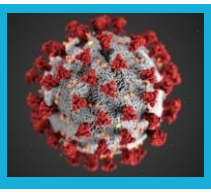


Record of Changes

Date of original version: October 16, 2020

Date Reviewed	Change Number	Date of Change	Description of Change	Name of Author



Executive Summary
October 2020

COVID-19's devastating impacts motivate New Jersey to build a robust COVID-19 vaccination program. In January 2020, the State of New Jersey started actively tracking the outbreak of a novel coronavirus. Since the COVID-19 public health emergency was declared through Executive Order No. 103 on March 9, 2020, New Jersey has mobilized a statewide, data-driven COVID-19 response that includes healthcare capacity expansion, focus on vulnerable populations, scaling of testing, contact tracing and exposure notification mobilization, resource provision, and resiliency planning. The State informs COVID-19 efforts through transparent information to the public and through funding and technical guidance to local partners.

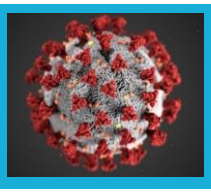
New Jersey began COVID-19 vaccination planning in the context of considerable unknowns regarding vaccine safety, efficacy, availability and timelines, federal distribution logistics, supplies and funding resources, public demand, likelihood of community protection through vaccination, and other factors. New Jersey submitted a Draft Interim COVID-19 Vaccination Plan to the Centers for Disease Control and Prevention (CDC) for feedback on October 16, 2020, but New Jersey will adapt its phased approach as unknowns are resolved.

Strategic Aims
- Provide equitable access to all who live, work, and/or are educated in New Jersey
- Achieve community protection, assuming vaccine effectiveness, availability, and uptake
- Build sustainable trust in COVID-19 and other vaccines

Equitable Access (Sections 1 and 5)
The COVID-19 public health crisis has widened and deepened the demographic of those who are vulnerable. Centering health equity in planning and delivery is fundamental to empowering all New Jerseyans and to eliminating disparities in vaccination and other public health outcomes. This includes:

- Involving diverse collaborators and perspectives in planning and delivery;
- Enabling data-informed consideration of risk, privilege, and vulnerability in prioritization and allocation;
- Partnering with trusted leaders for community education and confidence-building;
- Providing vaccination in safe, familiar, and convenient locations with hours that accommodate working families;
- Offering materials and instructions in the most common languages spoken in the state;
- Staffing points of dispensing sites (PODS) with patient navigators who are representative of the communities served;
- Using traditional and nontraditional communications channels to alert those with limited access to information about when, where, and how to receive vaccination and to empower informed decisions about vaccine safety and efficacy;
- Considering affordability options for uninsured, underinsured, and other vulnerable groups;
- Removing regulatory and legal barriers that unduly constrain participation; and
- Reviewing disaggregated data and transparently reporting to communicate process and progress.

A successful COVID-19 vaccination program will facilitate building a stronger, fairer, and healthier New Jersey.



Phased Approach (Sections 3, 4, and 7)

New Jersey is planning for three scenarios: initial significant vaccine scarcity (Phase 1), supply meeting demand (Phase 2), and slowing public demand (Phase 3). New Jersey is planning to scale all vaccine implementation elements with increasing vaccine availability. Across each Phase, New Jersey must earn the public's trust, communicate clearly and factually, and provide fair and equitable access. Capacities to be scaled include:

- Expanding outreach to all New Jerseyans and connecting with specific populations;
- Enrolling sufficient providers through concerted workforce recruitment and scopes of practice expansions;
- Ensuring technological and data infrastructure can meet increased usage and users;
- Deploying increasing capital, supplies, and human resources; and
- Monitoring equitable results and readjusting strategies and tactics accordingly.

In alignment with the National Academies of Sciences, Engineering, and Medicine's (NASEM) *Framework for Equitable Allocation of COVID-19 Vaccine*, New Jersey is building upon existing systems across all levels of government to provide necessary resources to ensure equitable allocation, distribution, and administration of COVID-19 vaccines. However, federal funding to New Jersey to-date is not anticipated to be sufficient to meet the resource needs for this complex, large-scale vaccination program.

Public Confidence (Section 12)

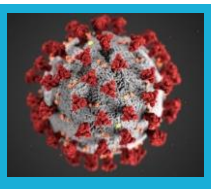
Building public confidence in safe and effective COVID-19 vaccine(s) is also a complex challenge. New Jersey seeks:

- To build trust across state, including among local public health, vaccine providers, and vaccines recipients;
- To understand how to ensure ease of access to the vaccine, and to information about the vaccine; and
- To cultivate a network of diverse partners committed to safe, accessible COVID-19 vaccination.

New Jersey aims to engender intergenerational trust in vaccination—to protect against COVID-19 and other vaccine preventable diseases. New Jersey is raising awareness, providing education, and activating action by arming stakeholders, partners, and the public with accurate, up-to-date facts. Credible and consistent health communication messaging will be shared across multiple platforms to address concerns of specific audiences using timely and science-based public health and medical information from trusted sources. Messaging will be culturally appropriate and translated into multiple languages.

State Leadership (Section 2)

New Jersey has a whole-of-government commitment to the COVID-19 vaccine effort. Preliminary planning began in April 2020 upon receipt of the CDC's initial assumptions. To plan and deliver New Jersey's equitable COVID-19 vaccine program, the Vaccine Task Force (VTF) convened in July 2020 has teams focused on Logistics and POD (Point of Dispensing) Delivery; Federal Interoperability, IT, and Data Flow; Specific Population Planning; Enabling Policy; Public Confidence; Strategic Communications; Analytics and Reporting; Management and Administration, including Consumer Affordability, Resourcing, and Funding; and Flu and General immunization Acceleration. The VTF reports into New Jersey's Coronavirus Task Force, which was established by Executive Order No. 102, comprises key Cabinet-level officials, reports to Governor Murphy, and continues to ensure that no constituency is unjustly left behind and that a health equity lens is applied.



Expert Guidance (Section 2)

Throughout the COVID-19 crisis, state leaders have engaged subject matter experts and thought leaders to guide New Jersey through this extraordinary and challenging time. The New Jersey Department of Health COVID-19 Professional Advisory Committee (PAC) was convened in March 2020 to inform the Commissioner of Health. The PAC provides guidance to the Department to ensure that New Jersey's response to COVID-19 is based on the latest scientific, medical, ethical, and public health evidence. The membership of the PAC and its subcommittees include New Jersey-specific expertise representing geographic, demographic, and professional diversity.

Since summer 2020 and as New Jersey progresses through COVID-19 vaccination rollout, the PAC may inform New Jersey's answers to such questions as:

- Have equity considerations been implemented at each stage of planning and delivery?
- Can the public have confidence that the available vaccine(s) is safe and effective?
- How will vaccine(s) be prioritized, or sub-prioritized given scarcity and operational constraints?
- How to ensure vaccine uptake is sufficient to facilitate, as possible, a return to pre-pandemic conditions?

Subcommittees focus on health equity, community advocacy, and medical ethics and systems. PAC recommendations are informed by New Jersey-specific epidemiological, occupational, geospatial, demographic data; federal guidance; public health expert data and literature; and forthcoming Advisory Committee on Immunization Practices (ACIP) recommendations. The PAC previously informed allocation of critical care resources, remdesivir distribution, and targeted population-specific testing strategies during this public health emergency. Final recommendations will be socialized to ensure diverse perspectives and a broad cross-section of New Jerseyans are integrated into planning.

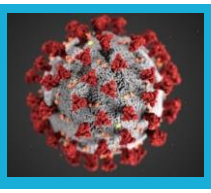
Critical Populations (Sections 3 and 4)

New Jersey intends to follow the CDC Phased Approach framework. This includes defining Phase 1a as healthcare workers, which New Jersey estimates will require one million doses of a two-dose COVID-19 vaccine to fully serve. Necessity of sub-population prioritization is anticipated given expectation of scarce vaccine availability at the onset and potential for supply shortages throughout. Logistics issues may constrain decisions and plans will evolve based on vaccine supply reliability and public demand. New Jersey's Plan includes those who live, work, and/or are being educated in the state. Informed by limited federal and national guidance to-date, New Jersey's planning considers factors including risk of acquiring infection, risk of severe morbidity and mortality, risk of negative societal impact, risk of transmitting disease to others, and social vulnerability. For example, New Jersey is recruiting long-term care facilities to participate in a federally supported distribution process via pharmacies.

Timely First-Dose Outreach and Second-Dose Reminders (Sections 1, 10, and 13)

To connect with New Jersey's diverse population, outreach will be made through healthcare provider partners; community-based, occupational or affiliation-based partners; and the media. Before arriving and on-site, consumers and vaccine administrators will have ready access to fact sheets, vaccine information statements, and other resources to make informed decisions.

In addition to existing reminder/recall mechanisms in the New Jersey Immunization Information System (NJIIS), additional options are being vetted to expand second-dose reminder capability. These include technological



solutions, strategic scheduling, hard copy vaccine card distribution, on-site and off-site Consumer Navigators, directive on-site communication, targeted reminders to vaccine administrators and primary care providers, collaboration with identified primary care providers, and partnerships with employers or local entities to leverage existing notification channels.

Efficient and Effective Local Delivery (Sections 2, 3, 5, 6, and 14)

Success in planning and implementation of the COVID-19 vaccines initiative will rely on close interstate and intrastate coordination (regional, county, and local level). Scenario planning has informed the State's dynamic PODS network plan, which accounts for the number, setting type, nature (e.g., closed or open), throughput, and location of the PODS that will be required at different capacity scales. The State is adopting "vaccine administration capacity," as defined by CDC, as the maximum achievable vaccination throughput regardless of public demand for vaccination. The State's planning assumption, therefore, is to vaccinate up to 70% of its current eligible population (non-pregnant adults). This is in line with Healthy People 2030's national target for influenza vaccine uptake.

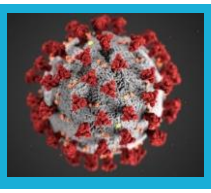
The number of PODS will be informed by the amount of vaccine available, the frequency of restocking, and the cold chain (or ultra-cold chain) requirements of the vaccine(s) that are federally authorized or approved. Geospatial mapping and facility infrastructure will also inform when and where sites are established. During Phase 1, PODS will include acute care hospitals, Local Information Network Communications System (LINCS) agencies, Local Health Departments (LHDs), retail pharmacies, Federally Qualified Health Centers (FQHCs), and other safe, familiar, and convenient locations. At scale, this will expand to static and mobile urgent care sites, large primary care clinics, and physician practices. Additionally, each county or LHD may have a large-scale site managed locally with some central support.

The State has identified the types of licensed health professionals qualified to administer COVID-19 vaccines. This will be reevaluated and potentially expanded contingent on supply and demand needs for increased vaccine administration workforce. At least two representatives from each enrolled site will be trained on topics including ACIP recommendations; COVID-19 vaccine ordering, receiving, storage, and handling; inventory management; NJIIS use; NJIIS reports to review the doses administered data; vaccine administration; management of vaccine wastage, spoilage, and temperature excursions; reporting adverse events to VAERS; and EUA facts sheets and/or vaccine information statements (VISs). Provider licenses will be validated by the New Jersey Division of Consumer Affairs and other state regulators.

Coordinated Inventory Management (Sections 7, 8, 9, 11)

NJIIS is the central registry, ordering, and reporting system. For ordering, once the federal government has indicated how much vaccine will be available to New Jersey and the state determines how to allocate statewide, site-level COVID-19 vaccine orders will be placed through NJIIS and transmitted via ExIS to VTrckS. The federal government, along with McKesson, will be responsible for the procurement and distribution of the vaccines to enrolled providers who ordered through VTrckS.

The provider site toolkit will include the CDC Vaccine Storage and Handling Toolkit and the CDC checklist for satellite, temporary, or off-site vaccine clinics. This guidance will describe roles and responsibilities for each site.



Under the CDC Provider Agreement, each site will have a Primary and Back-up Coordinator. Large-scale sites will also have a required Safety and Quality Assurance Officer, responsible for receiving vaccine shipments, monitoring storage unit temperatures, managing vaccine inventory, etc.

Sites will report all vaccine doses administered in New Jersey through direct entry, Excel spreadsheet submission, or HL7 connection to the NJIIS. Additional data may be collected through other vendor solutions like the federally-supported Vaccine Administration Management System (VAMS). New Jersey will participate in the IZ Gateway to ensure accounting for those vaccinated out of state. To adhere to the CDC reporting data and timeliness requirements, PODS must be adequately resourced.

The statewide Vaccine Command Center will be activated prior to the first delivery of vaccines to a distribution point and operate in close partnership between the New Jersey Department of Health, New Jersey State Police, county and state offices of emergency management, the National Guard, the New Jersey Office of Homeland Security and Preparedness, and local partners. This center will provide a single conduit for the flow of bidirectional information and intelligence related to the transport, delivery, and deployment of vaccines throughout the state.

Statewide Program Monitoring (Sections 1, 9, and 15)

New Jersey's health system resiliency is strengthened by investing in population health, promoting equity, and achieving better health outcomes for all New Jerseyans. The Institute of Medicine's six dimensions of quality health care—safe, effective, patient-centered, timely, efficient, and equitable—will be centered in COVID-19 vaccine planning, may be monitored quantitatively and/or qualitatively, and should be recalibrated as necessary during implementation. Quality improvement objectives include:

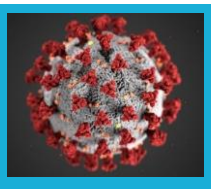
- Measurable increases in aggregate COVID-19 immunization uptake in comparison to other adult immunizations, and/or
- Measurable increases in aggregate COVID-19 immunization uptake in comparison to each prior phase of the COVID-19 rollout, and
- Sufficient immunization within critical populations to confer community protection.

At least weekly, the State will conduct check-in meetings with all local jurisdictions to monitor human and physical resources dedicated to the State's vaccination plan implementation.

Preliminary reporting goals include:

- Tracking vaccination status of high priority groups,
- Supporting consumer navigation and second dose reminders,
- Supporting provider communications and training,
- Ensuring effective distribution and use of vaccines,
- Monitoring site operational efficiency and throughput, and
- Ensuring effective consumer engagement.

To bolster the overall pandemic response, the State will link vaccination coverage reporting to the broader set of pandemic response measures, including disease progression and surveillance, healthcare capacity, and public health interventions. New Jersey will receive a Tiberius Analytic Support subject matter expert to optimize New Jersey's use of data monitoring available through federal systems. Mapping will provide visualization of vaccine coverage for the state by provider type, vaccine type, and population type.



Section 1: COVID-9 Vaccination Preparedness Planning

A. Early COVID-19 Vaccination Program Planning Activities

a. Lessons Learned: COVID-19 Pandemic Response and Resiliency

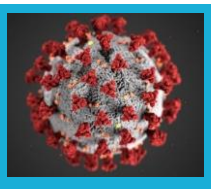
In January 2020, the State of New Jersey started actively tracking the outbreak of a novel coronavirus in Wuhan, China. On February 3, through Executive Order No. 102, Governor Phil Murphy established the Coronavirus Task Force—comprising key Cabinet-level officials and reporting to the Governor—to coordinate all State efforts to appropriately prepare for and respond to the public health hazard posed by the virus. By then, the New Jersey Department of Health (NJDOH) had screened 350 passengers at Newark Liberty Airport who had traveled from China and may have required isolation for 14 days. New Jersey had its first confirmed case of the virus on March 4 and the first death occurred on March 10. Governor Murphy declared a State of Emergency and Public Health Emergency effective March 9 under Executive Order No. 103 and has extended it every 30 days under subsequent executive actions.

The New Jersey Department of Health is central to New Jersey's response and resiliency through the designation of the Commissioner of Health as the chair of the interagency Coronavirus Task Force established under Governor Phil Murphy's Executive Order 102. Since the COVID-19 public health emergency was declared through Executive Order 103 on March 9, 2020, NJDOH coordinated the State's pandemic response, including but not limited to the allocation and distribution of critical supplies and personal protective equipment (including ventilators and therapeutic agents), health system capacity expansion, support for vulnerable populations (including those in congregate settings), the expansion of COVID-19 testing and contact tracing efforts, and provision of quarantine and isolation sites throughout the State. The Department collaborated with its local and state partners to provide guidance and direction on various areas of COVID-related response. A Command Center was established with daily briefings monitoring all data and surveillance information to guide a coordinated pandemic response. The Department guides and informs COVID-19 efforts through funding and technical guidance to local health departments and the provision of transparent guidance and information to stakeholders and the general public.

NJDOH's Vaccine Preventable Disease Program (VPDP) began planning for a COVID-19 pandemic vaccination effort in April 2020, when VPDP received the April 22, 2020 letter from the Centers for Disease Control and Prevention (CDC) outlining initial planning assumptions. VPDP's planning included an assessment of existing programmatic resources, including the New Jersey Immunization Information System (NJIIS) and other systems for ordering and managing federally funded vaccines. In summer 2020, this effort was broadened and formalized as detailed in Section 2.

New Jersey is motivated to build a robust COVID-19 vaccination program due to the COVID-19 pandemic's toll in:

- **Lives** – When the State of New Jersey started preparing internally in January, we knew that this virus could impact our state. Today, the enormity of its impact to New Jersey is truly unprecedented. The New York metropolitan area emerged as a global epicenter of the pandemic



and, at the time, the most severely impacted area in the United States. Every corner of our own state was similarly affected. As of October 16, 2020, there have been over 200,000 cases and, sadly, we have lost over 14,000 New Jerseyans to this virus. Across the nation, nursing homes and Assisted Living facilities have been the most severely impacted entities of the pandemic. New Jersey likewise suffered from a disproportionate percentage of approximately half of deaths among long-term care residents.

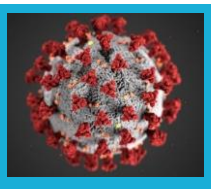
- **Delays in care** – The true toll of this virus may be never known. However, to date an estimated 50,000 admissions to the hospital have been attributed to this disease. Among those, some have suffered multi-systemic issues and prolonged recovery. Actions taken to mitigate the effects of COVID-19 included the closure of many businesses, including physician offices and routine care postponement and/or cancellation. This delayed residents from receiving care for the maintenance of their chronic conditions, many of which are linked to higher COVID-19 severity.

- **Mental health impact** – The pandemic has had a significant effect on the mental health of many New Jerseyans. In particular, essential healthcare and other front line workers, the newly unemployed, those experiencing difficulties with shelter-in-place, those personally impacted by COVID-19 disease or deaths from COVID-19, and, those with pre-existing mental health needs have increased mental health needs caused by the COVID-19 pandemic.

- **Health disparities –** Some communities in New Jersey have been impacted more disproportionately by the virus than others, including those residing in long term care and other congregate settings, communities of color, those residing in urban centers, health care and other frontline workers, and those with multiple comorbidities. The impact of the pandemic for many communities went beyond the immediate threat of contracting, spreading, and weathering the virus, and was compounded by the pervasive effects of social isolation and intersections with poverty, racism, and all forms of health and environmental injustice. For populations that we serve, these disproportionate impacts have exposed the health inequities which will be addressed in all parts of our response and recovery efforts, particularly in our vaccination planning. The catastrophic and unprecedented nature of this pandemic is particularly overwhelming for those who identify as at-risk, under-resourced, and underserved.

- **Livelihoods** – This pandemic has also unleashed an economic crisis only rivaled by two other times in our country's history – the Great Depression and the Civil War. COVID-19 has cost lives and livelihoods and devastated our nation's economy. While not a panacea, a safe and effective vaccine that is equitably and efficiently delivered with wide public acceptance will likely improve our economy and improve the lives of New Jerseyans.

- **Societal resiliency** – COVID-19 has dramatically changed societal interactions, leading to a struggle to find a "new normal" through the balancing of social customs against continued efforts to reduce the spread of the virus. While it is likely that a widely accepted and equitably delivered vaccine could reduce societal disruptions, it is necessary to remain vigilant by continuing evidence-based intervention activities, such as physical distancing, masking, hand hygiene, and active testing and tracing programs.



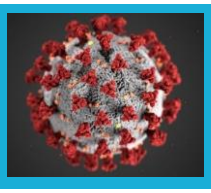
- **Healthier New Jersey** – A successful COVID-19 vaccination program will facilitate the building of a stronger, fairer and healthier New Jersey. One of the cornerstones of Governor Murphy's plan for the State's recovery is that public health yields economic health. In this process, we aim to engender intergenerational trust in vaccination—including the COVID-19 vaccine and vaccines for other preventable diseases. More broadly, the response must expand to all New Jerseyans fair and just opportunities to be as healthy as possible. As a result of the catastrophic nature of this public health crisis, the demographic of those who are vulnerable has widened and deepened. Centering health equity considerations in planning and delivery is fundamental to empowering all New Jerseyans and to eliminating disparities in vaccination and other public health outcomes.

New Jersey's COVID-19 response activities to date inform the planning and implementation of the COVID-19 vaccine plan. This public health emergency has required a whole-of-State effort that has challenged every aspect of government operations. Across the pandemic response, including the burgeoning COVID-19 vaccines effort, the following areas have informed preparedness, response, and resiliency in New Jersey:

- **Fostering public confidence** – New Jersey residents have overwhelmingly complied with evidence-based public health guidance, including stay-at-home orders, mask mandates, and participation in social distancing. Likewise, maintaining increased widespread testing (testing rates increased from a rate of 1,000 tests/day to a daily average of over 30,000 tests/day as of October 16, 2020) and participation in contact tracing efforts by "answering the call" will continue to be critical in reducing the spread of COVID-19. Sharing contact information for individuals that people have had close contact with helps protect them and their families. While we have made significant progress in some areas, we recognize that we must redouble our efforts to further increase public confidence. Development and release of new transparent consumer-facing technology, such as the COVID-Alert NJ App, will engage and encourage all residents to play an active role in the State's COVID response. New Jersey works continuously to dispel fear and misinformation about the Department's public health efforts, such as vaccination. Given the ongoing evolution of our understanding of this disease, which creates the potential for mixed messages and misinformation, this work takes on even greater relevance and importance.

- **Harnessing collaboration** – Strategic and tactical partnerships across government, jurisdictions, and communities have been fostered and mobilized to deliver public health interventions, health services, and social supports. For example, as part of our efforts to expand access, the State of New Jersey have engaged interfaith and community leaders to promote testing in their communities. The State of New Jersey provides technical assistance and resource coordination and is grateful to the local and county partners that drive delivery efforts.

- **Coordinating comprehensive public health response** – To respond to this novel pandemic, New Jersey has employed lessons learned and knowledge from its other continued public health efforts in testing, contact tracing, public awareness, vaccination, quarantine/isolation, and protecting vulnerable populations. There are process parallels between reducing the spread of COVID and other communicable diseases such as measles and influenza, by increasing public awareness,

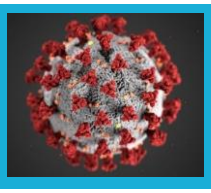


encouraging testing and vaccination, and quarantining when persons are symptomatic. New Jersey is diligently building a more robust public health workforce to protect our families and communities and stop the spread. At the start of the pandemic, the New Jersey had approximately 300 hardworking and dedicated contact tracers in local health departments. In response to COVID-19, New Jersey has onboarded and trained an additional 1,500 contact tracers to support State efforts. Additionally, NJDOH strongly advocated for enhanced testing and response efforts, for vulnerable populations and those living in congregate settings. For example, through its regulatory framework, NJDOH directed LTCFs to conduct regular COVID testing of its residents and staff. A Long-Term Care Emergency Operations Center (EOC) was established to provide a centralized command structure to manage pandemic response efforts, including monitoring of resident and staff COVID-19 testing and resources such as PPE, supplies, and therapeutics.

- **Promoting meaningful access** – To execute an effective COVID response, recognizing and rectifying gaps in access is incredibly important. For example, during the early stages of the pandemic, COVID testing was only available for symptomatic residents in very limited locations and primarily at drive-up sites. As testing resources became less constrained, the Department strategically expanded State testing efforts through amplification of county and local testing efforts, expanding testing to asymptomatic residents, and providing testing at locations beyond the traditional drive-through testing sites, including mobile pop-up testing sites utilizing federal testing resources through an expansion of the Community Based Testing Site program and procuring end-to-end testing services focused on six urban municipalities. Through these expanded testing efforts, over 4 million tests have been administered in New Jersey. Testing is widely available throughout the state – anyone can get tested and can find a testing location at covid19.nj.gov/testing.

- **Emphasizing health equity** – Throughout the pandemic, the State of New Jersey has been concerned about the disproportionate impact of COVID-19 on vulnerable populations, such as those in congregate settings, and communities of color. These disparities are evident from data published on the New Jersey COVID-19 Dashboard (https://covid19.nj.gov/). Across the nation and within the state, we have seen vulnerabilities to COVID-19 among these groups. To bridge this inequity gap, NJDOH has enhanced partnerships with State and county correctional facilities, expanded testing at LTCFs, correctional facilities, and State psychiatric hospitals, and piloted "boots on the ground" testing at senior high rises, and among persons experiencing homelessness and seasonal farm workers. Although these efforts cannot wholly reverse centuries of systemic, structural, socioeconomic, and health inequities, we recognize the need to continue shining a light on increasing equity in public health actions, particularly in the development of continued COVID response and planning.

- **Bolstering interagency resource coordination** – At the beginning of the pandemic, there were very limited supplies available to respond to a pandemic, particularly a virus that caused severe and sudden respiratory distress. The State of New Jersey did not have a stockpile of supplies and there were significant supply chain disruptions for PPE which exponentially increased both cost and delivery timeframes. The State received a series of deliveries from the Strategic National Stockpile, which was allocated and distributed to acute care hospitals, long term care facilities,



first responders, and correctional facilities. To enhance the State's continued preparedness efforts, an interagency coalition among NJDOH, the State Office of Emergency Management, and the Office of Homeland Security and Preparedness developed a joint resource management program, utilizing State-contracted secure warehouse space. This program led to the creation of operational inventory and development of an emergency supply stockpile to support State, county, and local response to a potential resurgence of COVID as well as any future public health emergencies.

- **Using iterative processes** – On May 18, Governor Murphy unveiled a multi-stage approach to execute the responsible and strategic economic restart to put New Jersey on the road back to recovery from COVID-19. New Jersey enters new stages based on data that demonstrates improvements in public health and the capacity to safeguard the public. The restart is phased within each stage, rather than opening all businesses and activities at once within a stage.

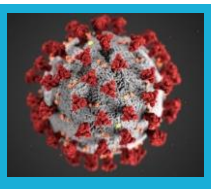
b. Lessons Learned: Routine Seasonal Influenza Vaccination Campaigns

Routinely and continuing during the COVID-19 pandemic, NJDOH's Vaccine Preventable Disease Program (VPDP) is responsible for two federal initiatives in New Jersey: the Vaccines for Children (VFC) Program and the 317-Funded (317) Adult Program. Through these programs, the VPDP annually distributes approximately 1.6 million doses of federally funded vaccines to approximately 900 registered providers throughout New Jersey. Registered providers include private healthcare providers, local health departments, Federally Qualified Health Centers (FQHC), and other non-profit organizations.

While NJDOH has robust systems in place for federally funded vaccines, most vaccine administration to children and adults in New Jersey occurs through private enterprises. Recently released data in CDC's Morbidity and Mortality Weekly Report (MMWR) indicates that 72.3% of children aged 6 months through 17 years of age received in influenza vaccine during the 2019–2020 flu season when compared to the national average of 63.8%. For adults 18 years of age and older, 45.2% were vaccinated compared to the national average of 48.4%. Overall, less than 50% of New Jersey's eligible population gets an influenza vaccine each year, whereas the national target established in HealthyPeople is 70%.

This year, New Jersey is preparing for a potential "twindemic" that would further strain healthcare resources. This year, more than ever, it is important that everyone six months of age and older without a medical contraindication gets vaccinated. While the influenza vaccine will not protect against COVID-19, it will protect those vulnerable to complications of the flu. New Jersey is promoting the CDC recommendation to receive influenza vaccination by the end of October.

To expand and accelerate influenza vaccination in 2020, the New Jersey Department of Health, Vaccine Preventable Disease Program used supplemental immunization funding to support stakeholders involved in influenza immunization efforts and to build the infrastructure for the upcoming COVID-19 immunization campaign. Specifically:



- **Persuasive Communications** – Funding was awarded to the Partnership for Maternal and Child Health of Northern New Jersey for a state-wide influenza campaign promoting the Power to Protect NJ.

- **Infrastructure and Cold Chain Capacity-building** – Funding was awarded to 10 Federally Qualified Health Centers (FQHCs) to build immunization infrastructure for influenza and for the upcoming COVID-19 immunization efforts.

- **Investments in Vulnerable Populations** – These FQHCs are 317-Funded Adult Vaccine providers routinely provide services to our most vulnerable populations within New Jersey and will serve critical roles to ensure equitable access to COVID-19 vaccines.

This year, we are emphasizing the importance of influenza vaccine during pregnancy as this group is unlikely to be eligible to receive the COVID-19 vaccine during the early phase of release since the vaccine has not yet been tested in this population. The VPDP is exploring opportunities to highlight flu vaccination among pregnant women.

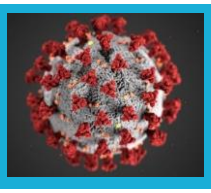
The NJDOH also encourages flu vaccination among healthcare workers since they work with vulnerable populations and are on the frontlines of the COVID-19 Pandemic. On January 13, 2020, Governor Murphy signed into law N.J.S.A. 26:2H-18.79 which requires influenza vaccination of healthcare personnel in certain settings. NJDOH is working with stakeholders to implement this new legislation.

Promoting flu vaccination means that we need ample supply of the vaccine for those providers who choose to vaccinate. Flu vaccine is produced by private manufacturers, so supply depends on manufacturers. Vaccine manufacturers have projected that they will supply as many as 194 to 198 million doses of influenza vaccine for the 2020-2021 season, the most ever.

Most flu vaccine that is administered in NJ is administered using privately purchased vaccine. The NJDOH VPDP does provide federally funded flu vaccines through the New Jersey Vaccines for Children (NJ VFC) and 317-Funded Adult (317 Program). These programs provide free or low-cost vaccines to providers who serve children and adults who face economic barriers to immunizations. This year, the Centers for Disease Control and Prevention (CDC) has allocated more federally funded vaccines to NJ:

- VFC – 433,870 doses allocated this flu season (361,000 doses allocated last season). These vaccines can be given to children who are Medicaid eligible, uninsured, underinsured, or American Indian/Alaskan Native.
- 317 Adult – 440,000 doses allocated this flu season (19,000 doses allocated last season). This year no eligibility screening for 317-Funded Adult flu vaccine which means that these adult doses can be given regardless of insurance status. 317-Funded adult vaccines usually require screening to ensure the recipient is uninsured/ underinsured.

The VPDP and Office of Primary Care and Rural Health, Community Health Services is collaborating to make $3.5 million dollars available to 10 FQHCs that are 317-Funded Adult vaccine providers. The immediate goal is to improve influenza vaccination rates in vulnerable populations and to build the infrastructure of vaccination clinics that can be used to administer the COVID-19 vaccine.



c. Lessons Learned: 2009 H1N1 Campaign

In addition, NJDOH reviewed after-action reports from the 2009 H1N1 vaccination campaign in which several divisions and programs played a major role in the NJDOH response. NJDOH has used the experience of 2009 H1N1 to inform planning efforts for COVID-19 vaccination efforts.

Key successes being replicated in the COVID-19 context include:

- **Streamlined ordering and distribution** – Providers directly ordered vaccine through NJIIS, based on initial priority groups, and CDC's distributor (McKesson) directly shipped both vaccine and ancillary supplies to ordering providers. The first vaccine was shipped to New Jersey the week of October 5, 2009. Demand was high, and supply was low until the end of November 2009.

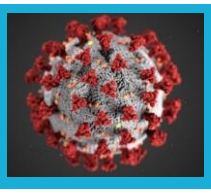
- **Broad-base of providers and administrators** – During the 2009 H1N1 pandemic, NJDOH had excellent working relationships with outside stakeholders including health departments, FQHCs, hospitals, schools and universities, retail pharmacies, large corporation occupational health services, and other state agencies (e.g., Department of Corrections, Department of Education, Department of Transportation). NJDOH shipped 2,592,500 doses of 2009 H1N1 vaccine to the following provider types:

Figure 1.a.iii-1: Types of PODS (Point of Dispensing Sites) used in NJ's H1N1 campaign (Source: NJDOH internal data, McKesson shipping reports)

Recipient POD Type	H1N1 Doses Shipped
Health Departments	1,327,900
Physicians and Employee Health	724,900
Hospitals	238,800
Federally Qualified Health Centers (FQHCs)	91,600
Colleges and Universities	85,700
Government/Confined	64,500
Retail	59,100
Total	**2,592,500**

- **Diverse communications channels** – There was a robust internal and external communication network including a vaccine information line for providers and a hotline for public calls. Over the course of the 2009 H1N1 pandemic, from 9/17/2009 to 3/30/2010, NJDOH received 14,300 calls from providers concerning registration, vaccine ordering, inventory management and temperature concerns, and recording doses administered. In addition, the public hotline fielded 33,463 calls from 10/6/2009 to 3/10/ 2010.

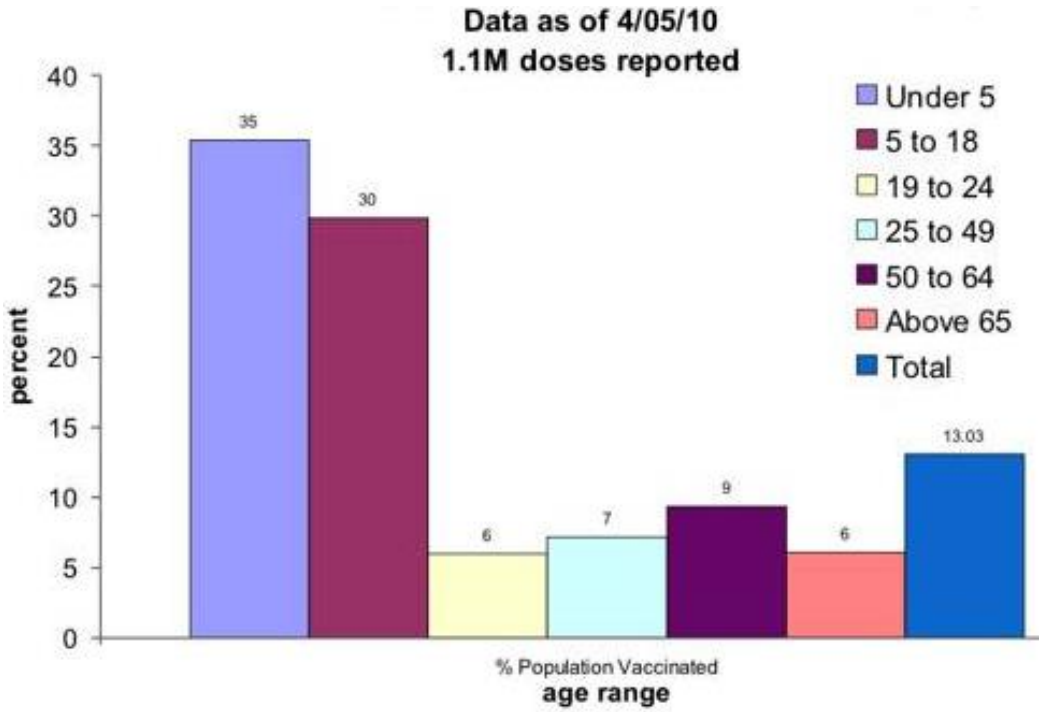
- **Adaptable operations –** The original plan to distribute vaccines from central locations with redistribution of product by state and local agencies evolved over the course of the pandemic to more direct shipments to vaccination service providers which was more in line with the distribution of federally-funded vaccine.



Key challenges informing quality improvements for the COVID-19 vaccines initiative include:

- **Inconsistent reporting** – Although 2,595,500 doses were shipped, only 1,112,193 were recorded as being administered as of March 30, 2010 (NJDOH unpublished data from H1N1 Vaccine System). Also, 10 percent of doses administered did not have a county of residence recorded and 33 percent did not have the municipality of residence entered. These deficits made tracking of vaccine and uptake difficult to assess.

Figure 1.a.iii-2: Percent of NJ Population Receiving H1N1 vaccine by age (Source: NJDOH internal data)

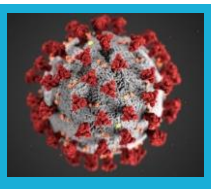


- **Poor data management** – There was difficulty accounting for all vaccine doses from delivery to administration and an inability to generate reports to provide timely, meaningful metrics.

- **Low public uptake** – Subsequent data published in the MMWR indicated poor uptake of 2009 H1N1 vaccine in New Jersey.

- **Insufficient provider training** – New providers who did not have experience using the New Jersey Immunization Information System (NJIIS) experienced challenges with vaccine ordering.

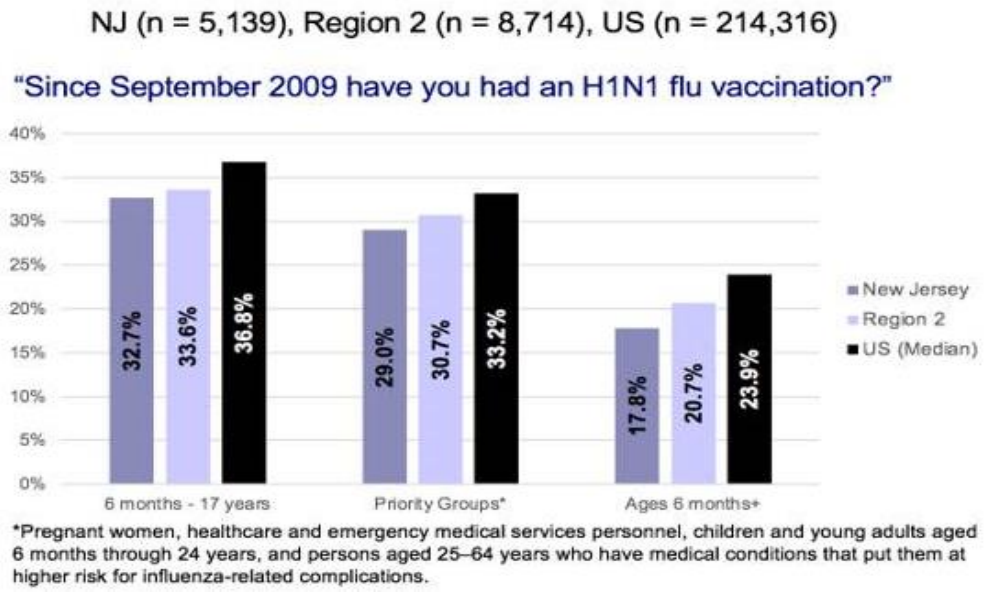
- **Deficient supplies** – Supplies that were supposed to accompany vaccine shipments from the CDC did not consistently arrive on time or had the incorrect supplies included (e.g., multiple dose vials of vaccine and needles but no syringes).



- **Scarce funding** – Programmatic operations were stymied by a lack of supportive funding. This COVID-19 Vaccination Plan is similarly predicated on the availability of funding.

- **Workforce inadequacy** – Inadequate number of trained staff within and outside NJDOH to support expanded programmatic operations.

Figure 1.a.iii-3: CDC/BRFSS/NHFS Phone Interviews November 2009 to February 2010 Regarding H1N1 Flu Vaccination (Source: MMWR 4/2/2010)



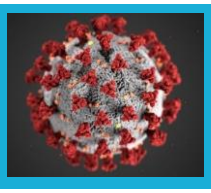
NJDOH has focused efforts to address gaps noted during 2009 H1N1. As elaborated elsewhere in this plan, New Jersey has already initiated efforts to address the following gaps:

- Defining metrics and developing methods to track key parameters during the vaccination campaign.
- Enhancing NJIIS capability.
- Developing systems to account for vaccines on a dose-for-dose basis.
- Supporting providers in on-boarding to NJIIS and in ordering COVID-19 vaccines.
- Collaborating with response partners to deliver vaccines at scale.
- Collaborating with a broad range of stakeholders to build public confidence and ensure equitable distribution of COVID vaccine.

B. Preparedness Exercises and Quality Initiatives

a. Lessons Learned: Workshops and Tabletop Exercises

Preparedness exercises specific to COVID-19 vaccines began in summer 2020 and have expanded and refined this plan and New Jersey's COVID-19 vaccines ambition. Exercises include but are not limited to:

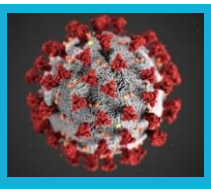


- Reviews of lessons learned from routine vaccination programs (e.g. seasonal influenza) and from prior pandemic vaccination (e.g. H1N1).
- Facilitated workshops across team leads and key NJDOH leadership to coalesce across work streams on shared principles and cross-cutting planning assumptions.
- Intensive end-to-end logistics and delivery tabletops to establish current state of play and opportunities to scale.
- Microsite visits provided by the Centers for Disease Control and Prevention and Operation Warp Speed focused on Points of Dispensing Sites (PODS), Public Confidence Communications, and Phased Approach for Critical Populations. Open questions asked of federal partners included but were not limited to:
    - Best practice guidance for supplies/infrastructure for PODS?
    - Best practice for repurposing and adding to the typical vaccine workforce given COVID-19 exigencies?
    - Availability of and costing of resources necessary to activate distribution at scale?
    - Availability of federal support in creation of communications resources for public confidence building, including toolkits and translated informational materials?
    - What operational, logistical, regulatory, communications, ethical, etc. considerations should NJ include in developing a Phased Approach?
    - Expectations for further federal guidance and resources in next planning stage and in initial delivery?
    - Delivery considerations for specific populations such as long-term care residents and staff?
- Collaborative discourse between NJDOH, Local Information Network Communications System (LINCS) agencies, and Local Health Departments (LHDs) to utilize lessons learned from their 2020 flu clinics and COVID-19 testing sites to inform their local and county COVID-19 vaccination plans.

Going forward, the State is planning to convene tabletop exercises with county and State offices of emergency management and local health departments to pressure test the planning assumptions and operational strategies that have been established in support of the State's COVID vaccination plan. These exercises will include:

- Workshopping around the State's vaccine security plan;
- Establishment of PODS throughout the State using a variety of dispensing sites (hospitals, FQHCs, pharmacies, urgent cares, and government-run sites);
- Stress testing throughput assumptions for each site as they relate to achievement of estimated daily vaccination projections to achieve the State's vaccination goal;
- Cold chain management;
- Vaccine administration and documentation;
- Traffic flow, social distancing, and sanitation measures; and
- Allocation and delivery of vaccines using the State's allocation model.

Dates for full-scale tabletop exercises, including those with external entities (e.g., FEMA) have not yet been established, but the State will provide updates to CDC once scheduled.



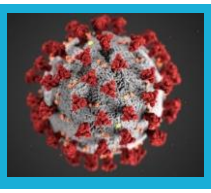
b. Continuous Quality Improvement Process

NJDOH's priority is to strengthen New Jersey's health system resiliency by investing in population health, promoting equity, and achieving better health outcomes for all New Jerseyans. NJDOH is committed to providing access to high quality, affordable, culturally competent, and trauma-informed care, as well as reducing and eliminating disparities in health outcomes across all health care services.

NJDOH's priorities align with evidence-based, national best practices, including the Institute of Medicine's six dimensions of quality health care:

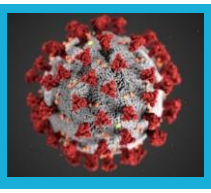
Figure 1.b.ii-1: Incorporate IOM dimensions of health care quality in envisioning COVID-19 vaccine quality

	IOM Definition	QI Example in NJ's COVID-19 Context
Safe	Avoiding harm to patients from the care that is intended to help them.	Is informed consent provided on the one or more novel vaccines for this novel coronavirus?
Effective	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).	How do the findings of clinical trials and recommendations of entities like the Advisory Committee on Immunization Practices (ACIP) inform which subpopulations are prioritized in initial phases (e.g. is vaccine more effective at preventing severe disease or preventing transmission?)?
Patient-Centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.	What is the user experience of each POD for New Jersey's diverse population?
Timely	Reducing waits and sometimes harmful delays for both those who receive and those who give care.	Are vaccine sites adequately staffed to avoid waits and ensure social distancing?
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy.	Are supply chains scalable, rapid, and reliable within New Jersey?
Equitable	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.	Is data collection inclusive and do disparities prompt action? *Further detail is provided in Section 5G about how New Jersey is leveraging a quality improvement mindset to advance health equity.*



Each of these dimensions is centered in COVID-19 vaccine planning, may be monitored quantitatively and/or qualitatively, and should be recalibrated as necessary during implementation. As noted by the CDC, "immunization is a dynamic, critical and measurable area of healthcare" and is thereby well-suited for continuous quality improvement.

Therefore, the overarching objectives of quality improvement for New Jersey's vaccine program will include: in comparison to other adult immunizations and/or in comparison to each prior phase of the COVID-19 rollout, measurable increases in aggregate COVID-19 adult immunization uptake and measurable increases in immunization within vulnerable critical populations sufficient to confer community protection.

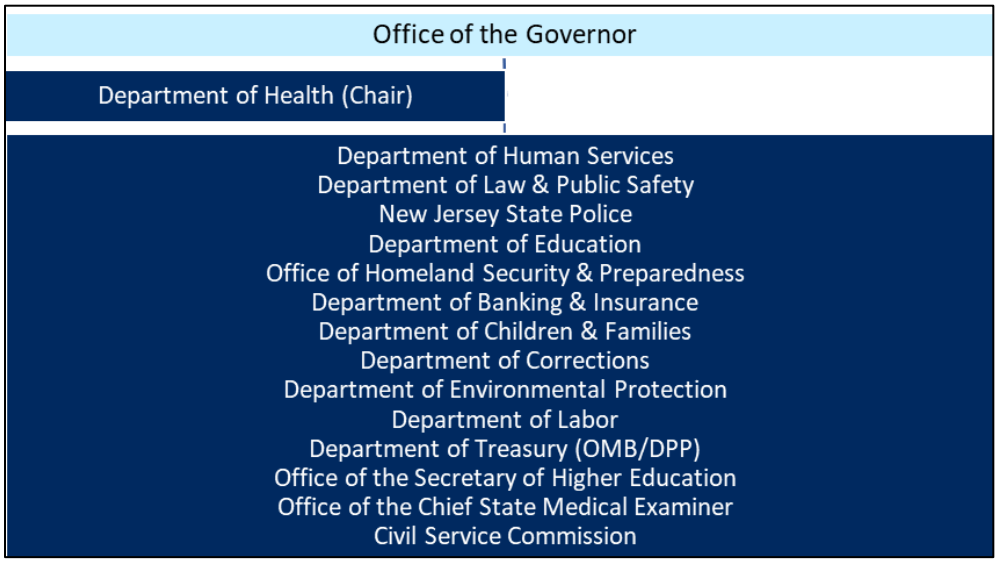


Section 2: COVID-19 Organizational Structure and Partner Involvement

A. Organizational Structure

In early 2020, the residents of the State of New Jersey began facing a major threat to our health and well-being due to the rapid spread of the novel coronavirus, SARS-CoV-2. On February 3, 2020, New Jersey Governor Murphy issued Executive Order 102, which created the Coronavirus Task Force (CTF) and designated the Commissioner of the New Jersey Department of Health (NJDOH) as the Task Force Chair. The primary purpose of the Task Force was to ensure and maintain the safety and security of New Jersey's 9 million residents. The CTF was charged with continuously monitoring national and global public health trends and developing and executing necessary and appropriate measures to protect its constituents threatened by the coronavirus.

Figure 2.a.1: New Jersey Coronavirus Task Force Members



In the days, weeks, and now months since, New Jersey has mobilized a comprehensive, data-driven COVID-19 response that includes testing, contact tracing, emergency preparedness, vaccines, and long-term care.

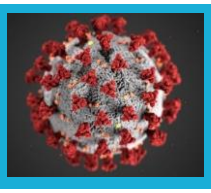


Figure 2.a.2: COVID-19 Response Sustainability Planning – Department of Health responsibilities

Testing	Contact tracing	Emergency preparedness	Vaccines	Long-Term Care
Testing strategy	CT recruiting	Monitoring disease progression	Logistics and PODS delivery	Long-term care quality and safety
NJ access strategy / operations	Onboarding / training	Broader surveillance management	Federal interoperability, IT, data flow management and surveillance	Emergency response to COVID in LTCs
Vulnerable population testing coordination	Workforce effectiveness management	Reopening guidance	Specific population planning	LTC policies and reopen guidance
County testing sites	CT efficacy	Safeguarding effectiveness	Enabling policy	Facility licensing and inspections
Testing vendor management	Digital contact tracing strategy	Rapid response team	Public confidence	LTC recommendations
Third party testing management	Digital contact tracing development	Stockpiling / procurement of essential resources	Strategic communications	Data / IT
State-led testing / sample collection	Support services integration	Regional collaborations	Analytics and reporting	
Lab – major lab management	Local quarantine	Surge capacity across healthcare settings with ability to cohort	Management and administration	
Lab – public / private partnership	Medical quarantine	Workforce stabilization and readiness	Flu vaccine acceleration and general immunization	
Corporate / private sector engagement	Public awareness / communications			
Public awareness / communications	Dashboards and analysis			
Dashboards and analysis	Data / IT (CommCare)			
Data / IT (CDRSS)	Corporate / private sector engagement			
Wastewater and serology	Exposure notification app			

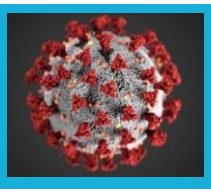
1 Staff training: cold chain – proper receipt, storage and temp. monitoring, inventory management, preparation and administration, transport, documentation (inventory, temp logs), emergency preparedness (e.g., power outage, storm)

Professional Advisory Committee and Sub-committees								
Epidemiological modeling	Funding	Procurement	Vendor management	Value assurance	State /3rd party engagement	Data / IT	Enabling policy	Reporting

On July 31, 2020, the Vaccine Task Force (VTF) was formally convened as an arm housed within the Department of Health to support the CTF's efforts to plan and implement a statewide COVID-19 vaccine program. The organizational structure began with the development of nine foundational teams, including:

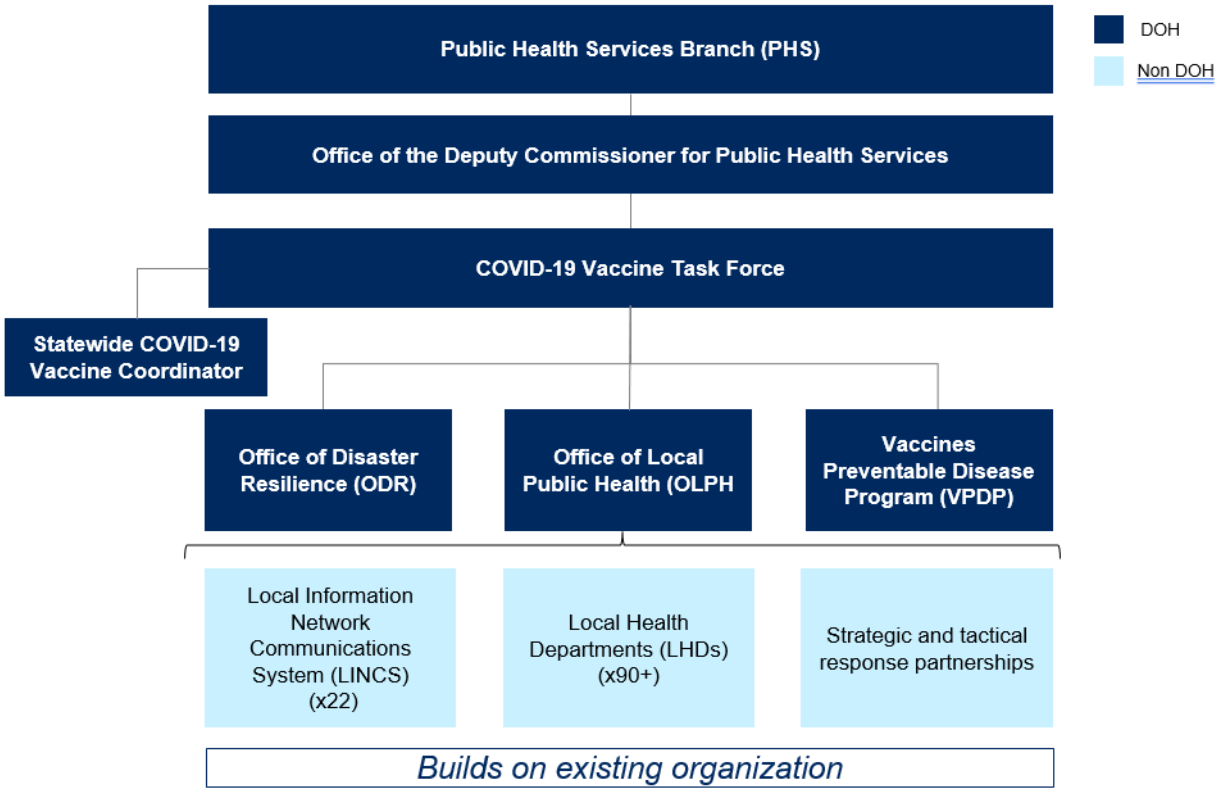
- Logistics and POD (Point of Dispensing) delivery,
- Federal Interoperability, IT, Data Flow Management and Surveillance,
- Specific Population Planning,
- Enabling Policy,
- Public Confidence,
- Strategic Communications,
- Analytics and Reporting,
- Management and Administration, and
- Flu Acceleration and General Immunization.

NJDOH has three principal branches: Health Systems, Public Health Services, and Integrated Health, and the cross-cutting Office of Population Health and Office of the Chief of Staff. The Vaccination Task Force resides within the NJDOH Public Health Services Branch and leverages the knowledge and efforts of various Branch programs, including the Office of Disaster Resilience (ODR), the Office of Local Public



Health (OLPH), and the Vaccine Preventable Disease Program (VPDP). Beyond the Public Health Services branch, the VTF incorporates expertise from across NJDOH in population health, data analytics, minority and multicultural health, law, policy, communications, fiscal, health information technology, etc.

Figure 2.a.3: COVID-19 Vaccine Organization within NJDOH – Working Structure



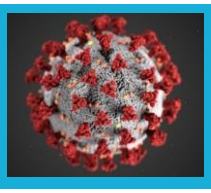
Given the whole-of-government commitment to the COVID-19 vaccine effort, as described in subsequent sections, representation from across state agencies and from the Office of the Governor are incorporated into the work group structure for COVID-19 vaccination planning and implementation.

Also incorporated formally or consultatively are statewide, regional, county, and local strategic and tactical partners. Advisory entities are also engaged in planning and will be pivotal to implementation.

B. Internal COVID-19 Vaccination Program Planning and Coordination Team

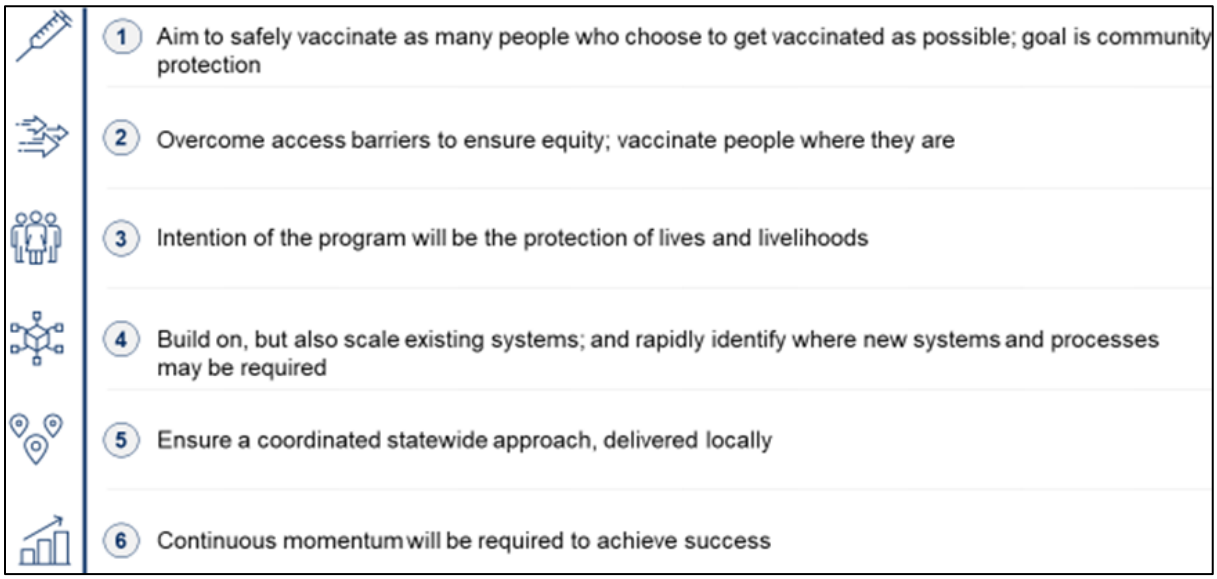
Purpose and Guiding Principles

An internal COVID-19 Vaccination Program planning and coordination team is critical to ensure the vaccination response to COVID-19 is thoughtfully planned and successfully executed. The State of New Jersey fully understands this imperative and developed a robust, cross-functional, and versatile COVID-19



Vaccine Task Force with a broad array of internal and external members. A set of guiding principles were established within the VTF to provide clarity and maintain focus in the preliminary planning phase. The inherent difficulty of planning a statewide vaccine program for a novel virus requires navigating unprecedented territory, therefore it is through these guiding principles that internal team engagement and collaboration are sustained.

Figure 2.b.1: Preliminary Guiding Principles for Internal COVID-19 Vaccine Planning



Overview of COVID-19 Vaccine Task Force

Core functions for the COVID-19 vaccine plan rollout are summarized below by work group. These functions were identified quickly and thoughtfully, identify a specific team for accountability, and require complex interdisciplinary coordination and collaboration. Two cross cutting elements—equity and funding—helped to guide the plan development and team functions.

Within each work group, a team-specific list of deliverables is maintained and monitored to ensure continuous progress, even in advance of COVID-19 vaccine availability. Each work group convenes collectively or in sub-groups throughout the week, with frequent cross-pollination and overlapping membership between the work groups.

The Vaccine Task Force is at full strength during the planning period and will continue during the implementation period.

In addition to internal actors, there are also numerous strategic partnerships that serve to support and assist in the development and implementation of the Statewide COVID-19 vaccination plan. Examples of operational strategic partners include acute care hospitals, long term care facilities, retail pharmacies, and FQHCs (Federally Qualified Health Centers).

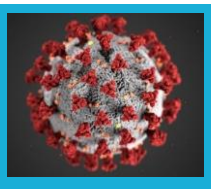
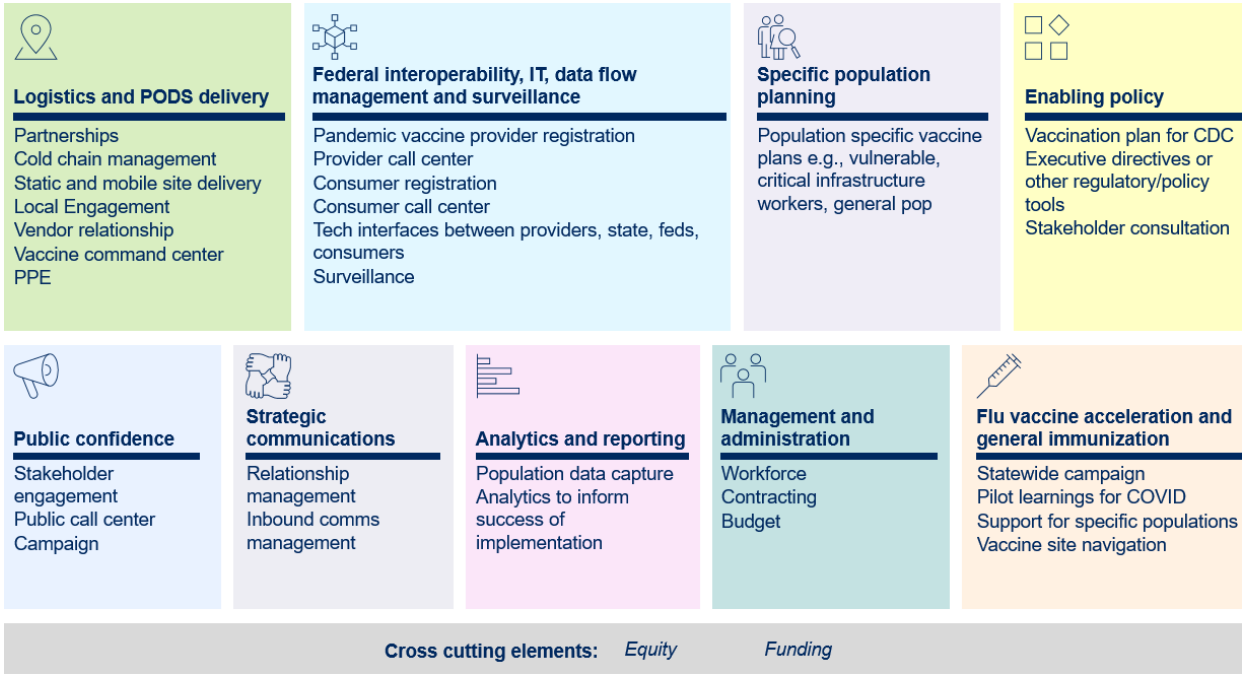


Figure 2.b.2: Core Functions for Each COVID-19 Vaccine Task Force Work Group



Overview of Team Membership

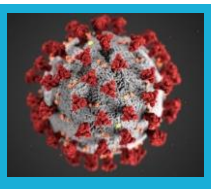
Each of the VTF's nine work groups onboarded qualified internal team members to support and add value to their team's respective deliverables.

Within state agencies, membership is not limited to NJDOH personnel and each team is intentionally multidisciplinary in nature. In addition to personnel from across NJDOH, illustrative examples of other agencies that are members of the COVID-19 vaccine work groups include, but are not limited to:

- Logistics: New Jersey Office of Emergency Management (NJOEM), New Jersey State Police (NJSP), Office of Homeland Security and Preparedness (OHSP)
- Enabling Policy: Office of the Attorney General
- Reporting: Department of Labor and Office of Homeland Security and Preparedness (OHSP)

As needed, the groups also expand their membership to engage participation from key stakeholder groups. For example:

- Logistics: New Jersey National Guard
- PODS: Key New Jersey Local Information Network Communication System (NJLINCS) and local public health (LPH) representatives, because the work of the VTF will be supported by the 22 NJLINCS agencies (21 at county level, 1 at local level) and over 94 local health departments (LHDs).
- Specific Populations: Inclusion of central members from diverse entities representing our critical infrastructure, vulnerable populations, and tribal communities.



Overview of Team Leadership

Departmental leadership identified team leads for each VTF work group. The team leads were selected by their professional credentials and experience that best suited their specific team. They include leaders that are both internal and external to the New Jersey Department of Health's Public Health Services Branch. Their collective expertise includes immunization, emergency preparedness, policy, public relations and crisis communications, information systems management, public health analytics, population health, management, and procurement.

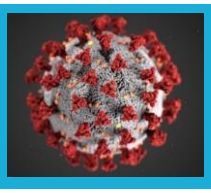
Overview of NJDOH COVID-19 Professional Advisory Committee

Throughout the crisis, state leadership has engaged subject matter experts and thought leaders to guide New Jersey through this extraordinary and challenging time. During COVID-19, intra-agency, inter-agency, and advisory groups have emerged to study, inform, and deliver health equity initiatives. These include, but are not limited to, an internal vulnerable populations workgroup that operates across sectors and communities that consolidates data relevant to action on health equity, inter-agency action on these issues through the Coronavirus Task Force and ad hoc interagency partnerships, and multi-sector advisory and action entities like the Governor's Response and Recovery Commission and Healthy New Jersey 2030.

Supporting the work groups of the Vaccination Task Force, one advisory body particularly informs and shapes the VTF's planning: the New Jersey Department of Health COVID-19 Professional Advisory Committee (PAC) and its subcommittees (Health Equity, Community Advocacy, and Medical Ethics and Systems). The NJDOH COVID-19 Professional Advisory Committee (PAC) was convened in March 2020 and pivoted to focus on vaccines in summer 2020. The PAC is specifically called to advise the Commissioner of Health to ensure that New Jersey's response to COVID-19 is based on the latest scientific, medical, ethical, and public health evidence. The COVID-19 pandemic has exacerbated existing and significant health inequities in our vulnerable communities. The recommendations provided by the PAC, and especially its Health Equity Subcommittee, will be fundamental in preventing health inequities during vaccine planning and distribution.

The Professional Advisory Committee informs the health response to COVID-19 in the following ways:

- *Resource Allocation* – How resources and services are procured, promoted, and provided in proximity to those who most need or require them to survive or thrive.
- *Advisory and Consultative* – Active communication to and from community and constituency perspectives to inform considered ethical and equitable planning, policy, and practice and to build public confidence.
- *Proactive and Participatory* – Deliberative ideation and derivation of novel solutions. Community involvement endeavors to inspire public confidence and sense of ownership in the generation, implementation, and evaluation of public health interventions.
- *Access* – A holistic assessment of whether affordability, availability, accessibility, accommodation, and acceptability are attained and advanced.
- *Quality* – A consideration of the safety, effectiveness, patient-centeredness, timeliness, efficiency, and equitability of proposed initiatives.



- *Outcomes* – A descriptive, data-informed, and transparent synthesis of which population(s) or who survives versus thrives, who is adversely impacted or resilient, who is affected by collateral or generational damage, and/or who is at-risk for a continuum of outcomes.
- *Problem-Solving* – An evaluation of which solutions transform the status quo by averting systemic and structural inequities and bias.

Committee expertise will be leveraged to enhance development, reach, and utility of overall and population-specific COVID-19 vaccination plans, policies, data-to-action, communications, and delivery activities. Specific issues previously addressed by the PAC include informing allocation of critical care resources (e.g. ventilators), distribution of scarce treatment pharmaceuticals (e.g. remdesivir), and targeted population-specific testing strategies. An integral role for the PAC is recommending to and advising the VTF on equitable vaccine prioritization and allocation.

The membership of the PAC and its subcommittees include New Jersey-specific expertise representing geographic, demographic, and professional diversity. Membership is informed by recommendations of the Centers for Disease Control and Prevention and the JHU Working Group on Readying Populations for COVID-19 Vaccine.

The NJDOH COVID-19 PAC charter and membership are enclosed in the Appendix.

C. Internal and External COVID-19 Vaccination Implementation Committee

The implementation of a statewide vaccination plan requires a supportive ecosystem across activated response partners and key stakeholders. While the NJDOH is the primary leader for coordinating the COVID-19 vaccination plan, other state and local agencies are essential at various stages of implementation. The State has identified three categories of partners to be engaged across purposes:

- **Response partners** – Such as Local Information Network Communications System (LINCS) agencies, Office of Emergency Management (OEM), Domestic Security Preparedness Task Force (DSPTF) etc. will support site setup and delivery including any necessary distribution logistics.

- **Specific population partners** – May be responsible for identifying, contacting and following up with critical populations. In Phase 1 and 2, these groups could include healthcare and essential workers' employers, relevant state agencies for their service users, community-based organizations, Regional Health Hubs, Federally Qualified Healthcare Centers (FQHCs), health insurers, etc.

- **Dispensing sites partners** – Will include hospitals, retail pharmacies, FQHCs, Local Health Departments (LHDs), urgent care centers, large primary care and multispecialty clinics will be responsible for end-to-end vaccine management including cold chain management, site setup (including equipment and supplies management),consumer registration, scheduling, second-dose follow-up, adverse event tracking, data gathering and reporting etc.

Public confidence building through mass, strategic, risk, and crisis communications will involve a cross-section of the above and additional stakeholders during the COVID-19 planning and rollout.

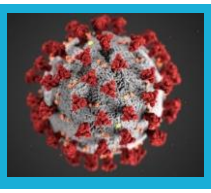
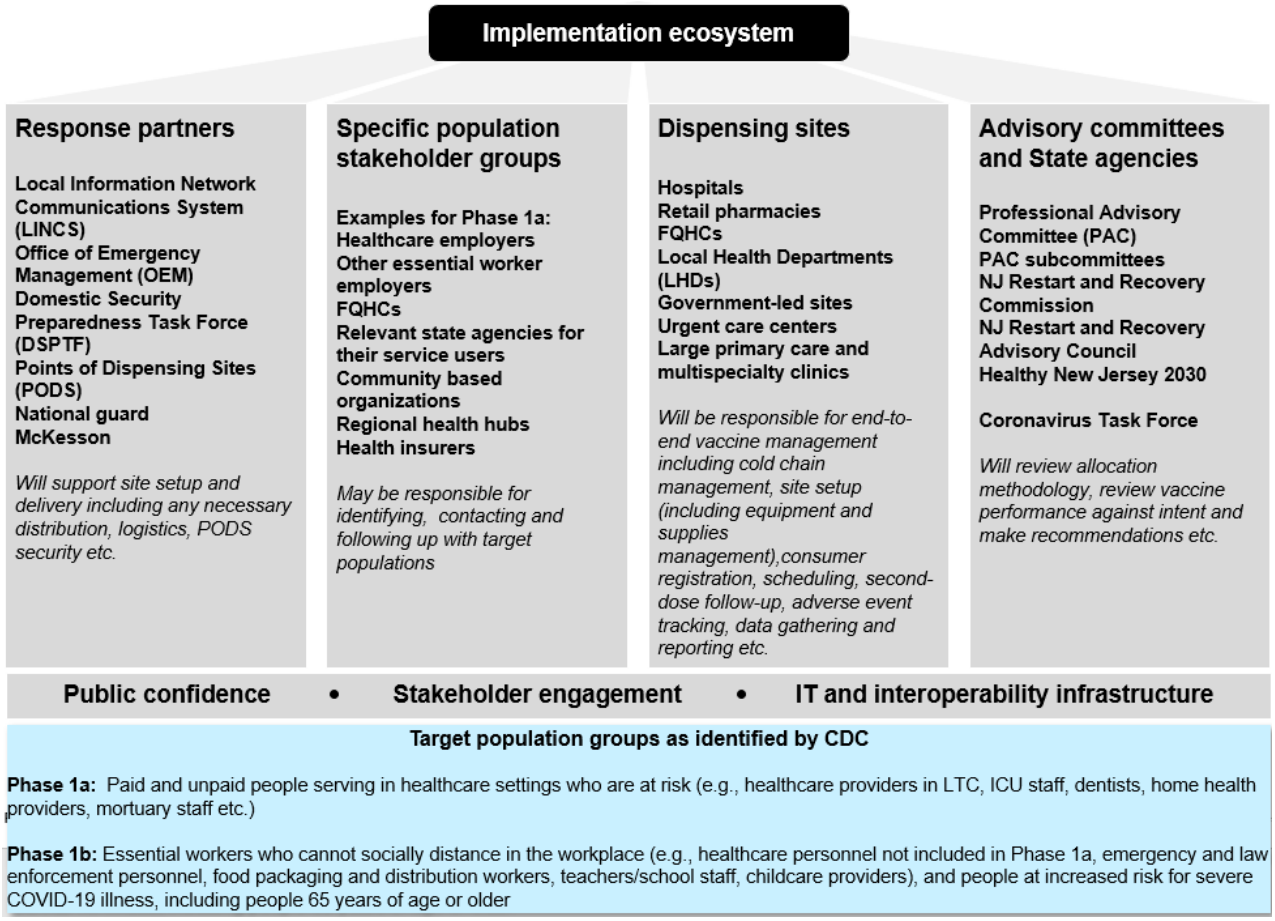


Figure 2.c.1: New Jersey's COVID-19 Vaccine Implementation Ecosystem



Internal implementation committees have been built into the VTF structure to support close coordination. Response partners have been identified and engaged across work groups.

The State is executing a stepwise plan to engage with a range of external stakeholders in advance of the first vaccine doses becoming available. These include leaders across multiple levels of government, professional associations, employers and community groups. A sequence of interactions has been planned out and mapped through a stakeholder mapping tool.

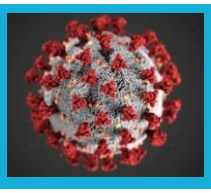
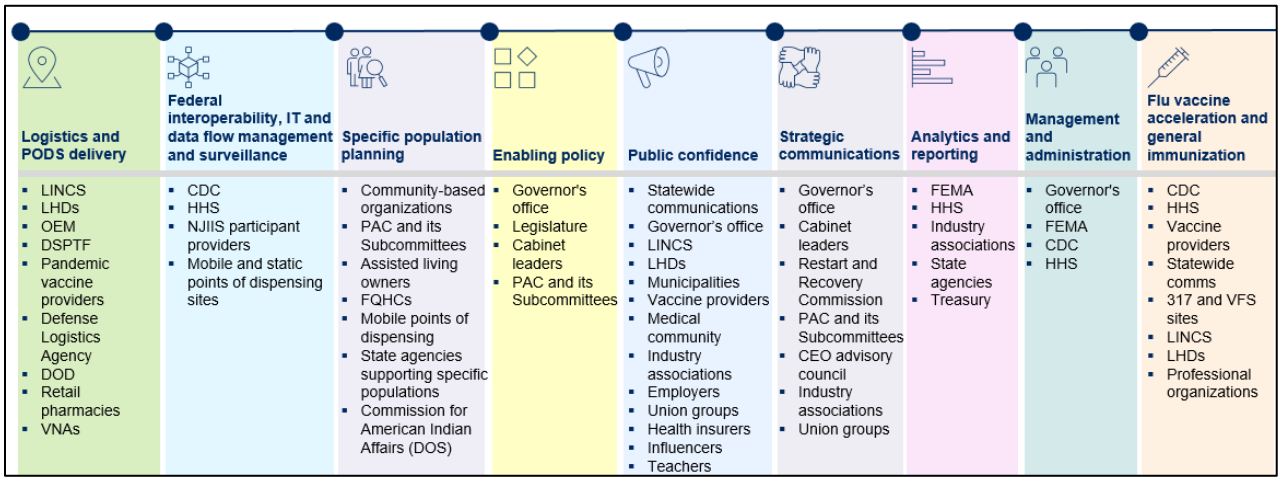


Figure 2.c.2: Key response partners across COVID-19 VTF work groups – illustrative, not exhaustive



Potential implementation partners across New Jersey were identified and classified according to CDC Playbook nomenclature:

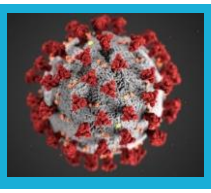
- State and local government
- Employers
- Healthcare providers
- Health insurance issuers and plans
- Education
- Unions and professional organizations
- Organizations serving minority populations and people with disabilities
- Community and faith-based groups
- General population
- Other essential workers
- Other

Groups were sequenced as:

- To be engaged before broader engagement
- To be engaged immediately once broader engagement has begun
- To be engaged during the planning process
- To be engaged before first doses become available

D. Team Membership

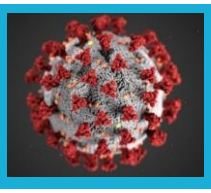
The Vaccine Task Force has been divided into nine working groups. The VTF is chaired by the Deputy Commissioner of Public Health, and each work group has one or two assigned Team Leaders equipped with internal organizational knowledge, as well as working partnerships with external members, stakeholders, and local health officials. Responsibility of each working groups' deliverables was shared amongst an expanding membership made up of expert contributors and directors in their respective fields of study and work (Figure 2.d.2).



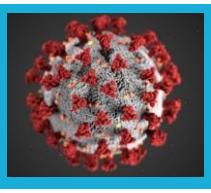
Each vaccination working group has been assigned a team lead with appropriate experience and expertise. The Statewide Vaccine Coordinator was designated to serve as the operational conduit for the nine VTF work groups. Team lead titles and biographical summaries are as follows:

Figure 2.d.1: COVID-19 Vaccine Task Force Team Leaders

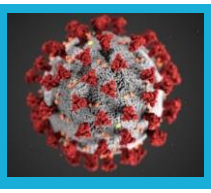
Team	Name	Title	Current role
Vaccine Task Force and Strategic Communications	David Adinaro, MD, MEng, FACEP	Chair of the Vaccine Task Force	Deputy Commissioner of Public Health Services, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Dr. David Adinaro serves as the Deputy Commissioner of Public Health Services for the NJDOH, which currently oversees the Divisions of Epidemiology; Environmental and Occupational Health; Family Health Services; HIV, STD, and TB Services; Medicinal Marijuana; Public Health Infrastructure, Laboratories, and Emergency Preparedness (PHILEP); and Offices of Local Public Health and Women's Health. Prior to his appointment as Deputy Commissioner, Dr. Adinaro was hired as the Chief Medical Officer for the COVID-19 Field Medical Station in Secaucus, NJ, which was facilitated in partnership with the NJ National Guard. His collective experience, in conjunction with his insights as the former Chief Medical Information Officer and Vice-President/Chief Medical Officer of St. Joseph's University Medical Center, designate Dr. Adinaro as the Chair of the New Jersey Vaccine Task Force		
Statewide COVID-19 Vaccine Coordinator	Patricia Drabik, DNP, RN, NEA-BC	Vaccine Coordinator	Director of Statewide COVID-19 Vaccine Coordination, Public Health Services Branch, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Patti Drabik has developed an expertise in operational and financial management in her former role as Administrative Director of Patient Care Services Finance and Resources for Saint Barnabas Medical Center. As part of NJ's response to the COVID-19 pandemic, Dr. Drabik joined the NJ Department of Health as the Chief Nursing Officer and Site Administrator for the COVID-19 Field Medical Station in Secaucus, NJ. In her role, she has activated the coordination and efforts of several operational partners, including, the NJ Commissioner of Health and the Superintendent of the NJ State Police, NJ Type 3 All-Hazards Incident Management Team, University Hospital and the UH Emergency Medical Services, NJ Army and Air National Guard under JTF-75, and a staff of 150 voluntary civilian healthcare providers. Dr. Drabik continues to support the COVID-19 Response by serving in the critical role as the Statewide COVID-19 Vaccine Coordinator.		
Vaccine Preventable Disease Program Lead and Flu Acceleration Lead	Barbara Montana, MD, MPH, FACP	Team Leader	Medical Director for Communicable Disease Service, NJ Department of Health
	Brief Summary of Experience that Supports Team Designation: She currently serves as the Medical Director for the Communicable Disease Service where she provides medical oversight for Vaccine Preventable Disease Program. Dr. Montana is Board Certified in Internal Medicine and Infectious Diseases. She has worked at the Department since 2004 and has played key roles in many public health emergencies impacting NJ including the 2009 H1N1 outbreak, outbreaks of measles and mumps, and outbreaks of serogroup B meningococcal disease associated with universities. In addition to being involved in the COVID-19 response, Dr. Montana is working to increase flu and other vaccine uptake in NJ. As such, her critical role in communicable disease outbreak management and vaccine programs, Dr. Montana has been designated as the Team Leader for Flu Acceleration and General Immunization.		



Logistics & PODS Delivery	Kaitlyn Woolford, JD	Team Co-Leader for Logistics	Executive Assistant to the Deputy Commissioner of Public Health Services, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Kaitlyn Woolford is the Logistics Team Lead and Executive Assistant to the Deputy Commissioner of Public Health Services of the NJ Department of Health (NJDOH) and has served in a number of critical roles throughout the COVID response, including serving as initial State testing lead, DOH liaison with the State Regional Operations Intelligence Center (ROIC) and the State Office of Emergency Management, State supervisor of federally supported community-based testing sites (CBTS), including the expansion of federally-supported mobile CBTS throughout the State. Her role as the team leader for Logistics is imperative as evidenced by her experience in working in concert with the Deputy Commissioner in the planning, organizing, and administration of program activities for the Public Health Services Branch.		
Logistics & PODS Delivery	Dana Johnson, MPH, CHES	Team Co-Leader for PODS Delivery	Director, Office of Disaster Resilience, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Dana Johnson's designation as Team Co-Leader derives from her extensive experience working at the NJDOH as part of the Public Health Emergency Preparedness Program and Hospital Preparedness Program. PODS Delivery falls under the scope of planning under the Office of Disaster Resilience (ODR). As Director, she currently has continued working partnerships with all external entity types, including, though not limited to, NJ Local Information Network Communications System (NJLINCS), Acute Care Hospitals, and Federally Qualified Health Centers (FQHCs). Ms. Johnson can leverage established mechanisms to enhance the capabilities of the statewide vaccination plan for the residents of New Jersey.		
Federal interoperability, IT, Data Flow Management & Surveillance	Bhavani Sathya, MPH	Team Leader	Director, Data Systems, Division of Epidemiology, Environmental & Occupational Health (EEOH), New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Bhavani Sathya oversees the data systems within the Division of EEOH, including the Communicable Disease Reporting and Surveillance System (CDRSS), Electronic Laboratory Reporting (ELR), and the New Jersey Immunization Information System (NJIIS). She also oversees various initiatives (working closely with the NJDOH Health Information Technology office and State Office of Information Technology) related to statewide and federal interoperability and technical infrastructure within the Division to ensure data systems meet with the latest national standards. She continues her work on the Governance Committee for the Epidemiology and Laboratory Capacity Grant (ELC), through which New Jersey has received significant funding for COVID-19. For the COVID-19 response, Ms. Sathya has been instrumental in implementing the statewide Contact Tracing program as co-leader, the COVID Alert NJ app, as well as ensuring case reporting into CDRSS. Her credentials and experience designate her as the Team Leader for the Federal Interoperability, IT, Data, Surveillance workgroup for the Vaccine Task Force.		
Specific Population Planning	Amanda Medina-Forrester, MA, MPH	Team Leader	Executive Director, Office of Minority and Multicultural Health, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: As Executive Director of the NJDOH's Office of Minority and Multicultural Health (OMMH), Amanda Medina-Forrester is charged with the responsibility to ensure health equity policies, practices, and programs are		



	implemented to reduce, and ultimately eliminate health disparities amongst diverse and marginalized populations. Her mastery efforts in this capacity has designated her as the Specific Population Team Leader. She has been able to fulfill this role by developing COVID-19 testing and spread-mitigation strategies in vulnerable populations, establishing vaccine implementation committees comprised of community members with access to critical populations, enhancing communication plans to access specific populations, as well as the engagement and activation of key stakeholders, community organizers, and tribal leaders.		
Enabling Policy	Jennifer Fearon, MPH	Team Leader	Policy Advisor, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Jennifer Fearon serves as NJDOH's Policy Advisor. Her functions include responsive (analysis), generative (development), and collaborative (implementation) dimensions of public health policymaking. Her broad portfolio lends a policy perspective to the Department's strategic priorities and to the de-siloing of policy, data, and programs. Responsibilities specific to the COVID-19 public health emergency include staffing the NJDOH COVID-19 Professional Advisory Committee and the Coronavirus Task Force, managing NJDOH's involvement in healthcare provider education with Rutgers Project ECHO, and contributing to COVID-19-related regulatory reforms. Her work and expertise in this space has designated Jennifer as the Team Leader for Enabling Policy work group.		
Public Confidence	Donna Leusner, BA, CDC certified in Crisis & Emergency Risk Communications	Team Leader	Director of Communications, New Jersey Department of Health
	Brief Summary of Experience that Supports Team Designation: Donna Leusner currently serves as the Director of Communications and has earned a certification from the CDC in Crisis and Emergency Risk Communications. Her designation as the Team Leader for Public Confidence is a result of her expertise in leading the NJDOH's public health awareness campaigns and media strategies for Ebola, H1N1, Zika, flu, Superstorm Sandy, blizzards, and other public health emergencies.		
Analytics & Reporting	Mehnaz Mustafa, MSc, MPH	Co-Team Leader	Executive Director, Healthcare Quality and Informatics
	Brief Summary of Experience that Supports Team Designation: As the Executive Director of Healthcare Quality and Informatics for the New Jersey Department of Health, Ms. Mustafa supports the State of New Jersey's COVID-19 response on predictive analytic modeling that determines potential surge capacity needs for the State of New Jersey. Additionally, she leads the analytics efforts on disease progression, health system capacity and resilience, testing, and the suite of core metrics which inform safe reopening decisions. She also provides a range of stakeholders with an interactive dashboard on State, County and Municipality level core metrics.		
Analytics & Reporting	Aaron Rosenbaum, PhD, MPH	Co-Team Leader	Research Statistical Analyst, Vaccine Preventable Disease Program, Communicable Disease Service, NJ Department of Health
	Aaron Rosenbaum is the Research Statistical Analyst for the Vaccine Preventable Disease Program (VPDP) in the Communicable Disease Service. His duties include the collection, processing, and analysis of population-based data on vaccine coverage and exemptions. He also works to assess and explain strengths and limitations of the data as it pertains to		



	immunization rates, disease surveillance, population assessment, and the Vaccines for Children Program. To perform his duties, he utilizes the data sources from which many of the metrics required for monitoring and evaluating the COVID-19 vaccine response will be derived. Dr. Rosenbaum has contributed to the state COVID-19 response constructing the survey and reporting infrastructure necessary to monitor and prioritize the epidemiological response to outbreaks at long-term care facilities.

E. Coordination between Jurisdictions

Success in planning and implementation of the COVID-19 vaccines initiative will rely upon close interstate and intrastate coordination.

Illustrative but not exhaustive examples of government-based or government-sponsored partners that have been mobilized during New Jersey's COVID-19 response for testing, contact tracing, social supports, quarantine/isolation, and other activities include:

- **Federal –** Federal agencies, especially Health and Human Services (including but not limited to Centers for Disease Control and Prevention), Operation Warp Speed, and Federal Emergency Management Agency; New Jersey's Congressional delegation.

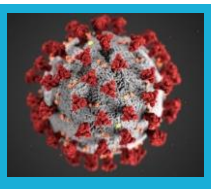
- **Interstate –** Contiguous and noncontiguous states. Especially frequent dialogues with neighboring states to accommodate New Jerseyans who may work or learn out-of-state, and vice versa.

- **Regional –** Pre-pandemic regional bodies like Maternal-Child Health Consortia and Regional Health Hubs as well as pandemic-specific regional entities like the Regional Collaborators (Level 1 trauma centers mobilized to regionally coordinate health systems). New Jersey is generally organized for the purposes of the COVID-19 response into three regions: Northern, Central, and Southern.

- **County –** 21 County Executives and Boards of Chosen Freeholders (soon-to-be "Boards of County Commissioners"); county health departments and offices of emergency management; 21 LINCS agencies.

- **Local –** Elected officials, including but not limited to mayors, township councils, and school boards; local health departments; LINCS agency (Newark).

For preliminary COVID-19 vaccination planning, the plurality of these partners already has been engaged by the State of New Jersey at the awareness, education, or action level. All are anticipated to be leveraged for ongoing strategic and tactical planning, technical assistance, and implementation collaboration and support. Given that New Jersey is a "home rule" state and given cross jurisdictional efforts in other aspects of the pandemic response, the State of New Jersey has a planning assumption of local delivery and close collaboration with regions, counties, and localities. Therefore, creating critical intrastate partnerships for New Jersey preparedness and response initiatives are especially important and continuously woven into the planning efforts.



New Jersey has benefited from support by professional organizations in coordinating and convening interstate collaboration in vaccination planning. These include but are not limited to Association of State and Territorial Health Officials (ASTHO), National Governor's Association (NGA), and National Conference of State Legislatures (NCSL). Within New Jersey, advisory bodies and professional societies have assisted in brokering coordinated planning and delivery. For example, the New Jersey League of Municipalities, the New Jersey Conference of Mayors, and the New Jersey Association of County and City Health Officials (NJACCHO).

F. Tribal Community Engagement

The Specific Population subcommittee is primarily responsible for the initial and ongoing engagement and coordination efforts with New Jersey's tribal communities and organizations.

The New Jersey Commission on American Indian Affairs, which sits within the New Jersey Department of State, includes representatives from each of the following State-recognized tribes:

- Nanticoke Lenni-Lenape,
- Ramapough Lenape, and
- Powhatan Renape.

Each tribal community has approximately 3,500 to 5,000 members within New Jersey's boundaries.

New Jersey's Vaccine Task Force's early engagement activities included inviting a tribe member to join the Specific Population team and joining recent Commission on American Indian Affairs meetings to discuss COVID-19-related work, most particularly COVID-19 testing. As a result, a COVID-19 Testing and Education Needs Assessment was conducted through an online survey and ongoing phone interviews. In keeping with the safety measures and physical distancing requirements during collaborative efforts, communication will primarily be web and phone-based until the dynamic needs of the Vaccines Task Force change.

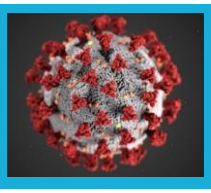
G. Key Partners for Critical Populations

Example Supply-Side Partners to Serve Critical Populations

In planning for a phased rollout of COVID-19 vaccines, the VTF has identified key external partners for the local delivery of COVID-19 vaccines to critical populations. These include, but are not limited to:

- **COVID-19 Vaccine Dispensing Partners** – In Phase 1, when limited doses are available for populations identified in Phase 1a (high-risk healthcare workers) and 1b (essential workers and those at high-risk), PODS will include hospitals, NJ LINCS agencies, and their affiliated LHDs, retail pharmacies, and Federally Qualified Health Centers (FQHCs).

  Once large supplies of vaccines are made available, additional PODS will be required, including retail pharmacies, urgent care sites, large primary care clinics, and physician practices. Additionally, each county or LHD may have a large-scale site to support the rollout of COVID-19



vaccines at scale. These sites will be managed by the LHD, municipality, and/or county OEM with some central support.

The number and type of COVID-19 vaccine providers targeted for participation will be based on the available supply and recommendations from the Advisory Committee on Immunization Practices (ACIP), CDC, National Academies of Sciences, Engineering, and Medicine (NASEM) and other entities. Eligibility determinations will be coordinated and operationalized through the Office of the Attorney General's Division of Consumer Affairs, which includes the licensing boards for health professionals. This process may be dynamic and may require iteration.

- **COVID-19 Vaccine Response Partners** – Response partners will support several planning activities, including, though not limited to, key distribution activities, vaccine operations and logistics, and PODS security. It is expected that the federal government, along with McKesson, will be responsible for the procurement and distribution of the vaccines to the enrolled providers who ordered them through VTrckS. The OEM, in coordination with the NJ National Guard, NJDOH, and the provider networks, which include LINCS agencies, health systems, and retail pharmacies , will support the management and configuration of the PODS, cold-chain logistics, security, and staffing support at large-scale county sites.

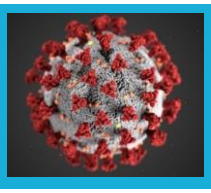
Example Demand-Side Partners to Serve Critical Populations

The State of New Jersey has mapped key governmental and nongovernmental touchpoints for critical populations throughout each phase of the COVID-19 vaccine rollout. Non-exhaustive exemplars include:

- **COVID-19 Vaccine Specific Population Partners** – Group leaders from communities, faith-based organizations, employers, and other state agencies will play a critical role in identifying and contacting the populations identified in Phases 1a and 1b. They will also play a role in communicating with these groups and may be leveraged for additional second dose reminders. They will be engaged during the establishment of PODS to ensure the appropriate groups can get sufficient access.

- **Leveraging Existing Public-Private Partnerships –**

    - Example: Community and Faith-based organizations – Since 1991, NJDOH Office of Minority and Multicultural Health (OMMH) has provided resources from the General State Fund to engage and support community and faith-based initiatives, such as assertive outreach, education and patient linkage to healthcare services, aimed at eliminating health disparities. For instance, the OMMH's Community Health Disparity Prevention Program currently funds 18 organizations to implement evidence-based strategies or promising practices to reduce health disparities for a targeted population within the community. OMMH partners with governmental, non-governmental agencies and organizations and maintains a strong relationship with New Jersey local public health offices to support minority health and promote activities to reduce health disparities.



Additionally, OMMH also maintains relationships with the New Jersey Primary Care Association and FQHCs that are included in all OMMH's community outreach activities.

- Example: Foundations – In another example of prior stakeholder engagement with community-based organization and local foundations, the NJDOH thirteen-member Healthy New Jersey (HNJ) Advisory Council (HNJAC) was formed in September 2019 and has met monthly with DOH's HNJ Coordinating Committee (HNJCC) leadership since then to further the development of HNJ2030. Substantial engagement via email, video conference, and phone calls between HNJAC members and with HNJCC members has occurred over the past year in addition to the monthly meetings.
- Example: Academic Institutions – NJDOH maintains strong collaborations with universities, graduate schools and centers of socio-economic research to engage and support these institutions in the study of health disparities and socio-economic determinants of health. As an illustration, OMMH has supported the Rutgers' African American Brain Health Initiative: A University-Community Partnership.
- Example: Regional Health Hubs – Under 2020, NJ legislation, the Camden Coalition, Trenton Health Team, Greater Newark Healthcare Coalition, and the Health Coalition of Passaic County were designated as New Jersey's first Regional Health Hubs. Since 2011 these organizations have been Medicaid Accountable Care Organizations. Through their positions as health leaders in their communities, the hubs support the State of New Jersey's health priorities by providing healthcare data infrastructure and analysis, supporting care management, and convening community stakeholders in close coordination with the state's Office of Medicaid Innovation. In the past year, the four organizations have worked with NJDOH to address inequities in maternal health outcomes, access to cancer screening and treatment, challenges in access to healthy food, connections between healthcare and the faith community, youth tobacco use prevention, school attendance, improvements to the built environment, and more. They are currently engaged as participants in public confidence focus groups that will shape community messaging.

- **Building Upon Existing Public Service** – New Jersey has matched state agencies against critical populations to promote leveraging of existing relationships between government entities and the specific constituencies each serve. Included here is a broad summary. In practice, each state office may be called upon to leverage its relationships with its grantees, licensees, stakeholders, partners, and constituencies.

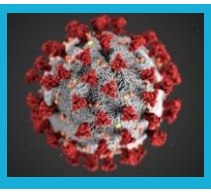


Figure 2.g.1: Populations by CDC phasing and their relationships to state agencies (Part 1 of 3)

	CDC Phases	Example subgroups	Key touchpoints – state agencies
Healthcare workers	1A	Hospital workers LTC workers Veteran's home workers Home care workers Ambulatory and urgent care clinic workers Dialysis center workers Dental offices workers Morticians and funeral home workers Pharmacy workers Other non hospital healthcare facilities Public health workers (e.g., FQHCs) Group home workers Other paid and unpaid licensed and unlicensed healthcare workers EMS personnel	▪ Department of Health ▪ **Division of Consumer Affairs** ▪ **Department of Children and Families** ▪ **Department of Human Services** ▪ **Department of Military and Veterans Affairs** ▪ **Office of the Chief State Medical Examiner**
First responders	1B	Police Firefighters Other First Responders	▪ Department of Health ▪ **Office of Emergency Management** ▪ **Department of Community Affairs**

Figure 2.g.2: Populations by CDC phasing and their relationships to state agencies (Part 2 of 3)

	CDC Phases	Example subgroups	Key touchpoints – state agencies
Other essential workers	1B	Food service workers Port authority workers NJ transit workers Teachers, staff, and childcare workers Other critical workers CISA Other essential workers	▪ **Department of Labor** ▪ **Port authority** ▪ **NJ Transit** ▪ **Department of Education** ▪ **Office of the Secretary of Higher Education (OSHE)** ▪ **Office of Homeland Security and Preparedness (OHS&P)** ▪ **Department of Children and Families**
People at high risk of COVID-19 illness (cont'd)	1B	People at all ages with comorbid and underlying conditions that put them at high risk of COVID-19 (e.g., hypertension, obesity, cardiovascular disease, diabetes, chronic lung disease, cancer, chronic kidney disease, immuno-compromised, sickle cell disease) People living in congregate or overcrowded settings - LTC People living in congregate or overcrowded settings - Veterans homes People living or working in congregate or overcrowded settings - Correctional facilities (prisons, juvenile centers, county jails)	▪ Department of Health ▪ **Department of Human services** ▪ **Department of Military and Veterans Affairs** ▪ **Department of Corrections**

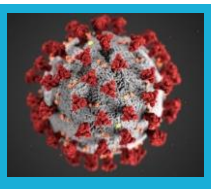
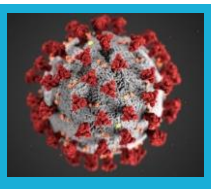


Figure 2.g.3: Populations by CDC phasing and their relationships to state agencies (Part 3 of 3)

	CDC Phases	Example subgroups	Key touchpoints – state agencies
(cont'd) People at high risk of COVID-19 illness	1B	People living or working in congregate or overcrowded settings - People experiencing homelessness People living or working in congregate or overcrowded settings - IDD group homes People living or working in congregate or overcrowded settings - Mental health group homes People living or working in congregate or overcrowded settings - Colleges and universities People living in congregate or overcrowded settings - Psychiatric hospitals People living or working in congregate or overcrowded settings - Migrant workers People living or working in congregate or overcrowded settings - Other Tribal populations Other People at high risk of COVID-19 illness due to comorbidities, occupations, demographics, etc.	▪ **Department of Children and Families** ▪ **Department of Human Services** ▪ **Office of the Secretary of Higher Education (OSHE)** ▪ Department of Health ▪ **Department of Agriculture** ▪ **Department of Labor** ▪ **New Jersey Commission of American Indian Affairs**
People 65 or older	1B	People over 65	▪ **Department of Human Services** ▪ Department of Health ▪ **Department of Labor**



Section 3: Phased Approach to COVID-19 Vaccination

New Jersey is planning to scale all vaccine implementation elements with increasing availability of vaccines to New Jersey. In this section, two dimensions are described in depth: eligibility to receive vaccine in each Phase and delivery system settings in each Phase. Communications strategies to cultivate public confidence through vaccine promotion campaigning, risk communication, and engagement in each Phase are described in Section 12.

Across all Phases, New Jersey will increase its capacity in every dimension, including but not limited to:

- Expanding outreach to all New Jerseyans;
- Enrolling sufficient providers through expansions in scopes of practice and concerted workforce recruitment;
- Connecting with increasing numbers and diversity of specific populations;
- Ensuring technological systems and data reporting capacity can meet increased usage and users;
- Deploying increasing capital, supply, and human resources;
- Monitoring equitable results and readjusting strategies and tactics accordingly. Iteration is key and New Jersey will adapt its phased approach as unknowns are resolved.

Across each Phase, New Jersey must earn trust, communicate clearly and factually, and provide meaningful access.

In accordance with the National Academies of Sciences, Engineering, and Medicine's *Framework for Equitable Allocation of COVID-19 Vaccine*, New Jersey is building upon existing systems across all levels of government to provide necessary resources to ensure equitable allocation, distribution, and administration of COVID-19 vaccines.

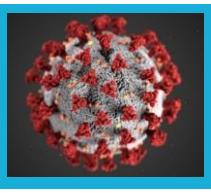
However, like the National Academies of Sciences, Engineering, and Medicine has found, the State of New Jersey does not anticipate that federal funding to NJ to-date will be sufficient to meet the resource needs for this complex, large-scale vaccination program.

New Jersey recognizes that there may be a mismatch between vaccine supplies and public demand, so these factors may inform when New Jersey progresses between Phases: federal guidance, vaccine availability, time, public uptake, coordination across jurisdictions.

A. Phase 1: Potentially Limited Doses Available

Prioritization and Allocation:
New Jersey intends to follow the Centers for Disease Control and Prevention (CDC) framework and overarching definition for the broad outline of Phase 1a and Phase 1b.

Within those initial Phases, sub-population prioritization is anticipated given expectation of scarce vaccine availability at the onset and potential for supply shortages before vaccine manufacturing and distribution reaches scale. Further detail on the process is provided in Sections 4C (sub-group prioritization) and 7A (allocation).



Prioritization and allocation decisions will be constrained by logistical considerations (e.g. expectation that a site must be able to administer at least 1000 doses per allotment, at least initially), and will evolve with further clarity regarding reliability of vaccine supply and public demand.

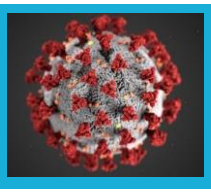
For planning and tabletop exercise purposes and informed by limited federal and national guidance to-date, the working assumptions as preliminarily recommended by the NJDOH COVID-19 Professional Advisory Committee are listed:

Note: While these factors have been proposed to inform discussions specific to the first doses available in Phase 1a, they may also inform action in later phases depending on supply provided to the State of New Jersey.

Note**:** Many prioritization and allocation items remain in process, including but not limited to definitions for each specific subgroup population and for how best to operationalize each "risk" type in New Jersey.

Note: These will be validated through governmental and nongovernmental channels, and are subject to change given feedback, further information (including results of vaccine trials, additional federal guidance, and Advisory Committee on Immunization Practices recommendations), New Jersey's public health surveillance, modeling, reporting, and survey data, and other factors.

- Units of who is vaccinated: Individual only.
- Eligibility in Phase 1a:
    - Inclusive of those who live, work, and/or are educated in New Jersey.
    - CDC's Phase 1a = "Paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials and are unable to work from home."
- Eligibility in Phase 1b:
    - Inclusive of those who live, work, and/or are educated in New Jersey.
    - CDC's Phase 1b =
        - "Other essential workers."
        - "People at higher risk of severe COVID-19 illness, including people 65 years of age and older."
- Preliminary criteria for determining an equitable allocation (as defined by NASEM):
    - *Risk of acquiring infection*: Higher priority given to individuals who have a greater probability of being in settings where COVID-19 is circulating and exposure to a sufficient dose of the virus.
    - *Risk of severe morbidity and mortality*: Higher priority given to individuals who have a greater probability of severe disease or death if they acquire infection.
    - *Risk of negative societal impact*: Higher priority given to individuals with societal function and upon whom other people's lives and livelihood depend directly and would be imperiled if they fell ill. It does not consider their wealth or income, or how readily an individual could be replaced in a work setting, given labor market conditions.
    - *Risk of transmitting disease to others*: Higher priority given to individuals who have a higher probability of transmitting the disease to others.



- *Social Vulnerability Index of residence location:* Developed by CDC for local preparedness for public health emergencies such as natural disasters and disease outbreaks, identifies geographic areas of vulnerability based on U.S. Census variables. These variables capture many recognized social determinants of health, indicators of access, infection transmission, and increased risk of adverse COVID-19 outcomes. Inclusion of this Index by NASEM and by NJ is motivated by the disproportioned higher rates of COVID-19 transmission, morbidity, and mortality among communities of color. As NASEM describes: "This reflects the impact of systemic racism leading to higher rates of comorbidities that increase the severity of COVID-19 infection and the socio-economic factors that increase likelihood of acquiring the infection, such as having front-line jobs, crowded living conditions, lack of access to personal protective equipment, and inability to work from home."

PODS:
The number of PODS will be informed by the amount of vaccine available, the frequency of restocking, and the cold chain parameters of the vaccine(s) authorized or approved. Geospatial mapping and facility capacities (e.g. ultracold chain) will also inform which sites are established.

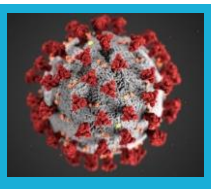
During Phase 1, NJ will dispense vaccinations to identified target groups at one or more of the following: acute care hospitals (health care workers), at regional/county LINCS PODs (first responders, critical infrastructure, vulnerable populations), and FQHCs (vulnerable populations).

- New Jersey is planning for Phase 1a to be dispensed in closed PODs established by county level health departments and acute care hospitals. New Jersey aims for acute care hospitals to hold closed PODs for eligible employees and open PODs for other Phase 1a eligible healthcare workers.
- Additionally, a select number of LINCS agencies or local health departments may be engaged to establish PODS to ensure efficient deployment of vaccine, contingent on supply and demand. These could operate locally, county-wide, or regionally based on these dependencies.
- During Phase 1b, NJ will continue closed and open PODs at acute care hospitals to vaccinate any Phase 1b healthcare workers. NJ is working with large critical infrastructure sites that may be included in Phase 1b to establish closed PODs. Vulnerable populations and other critical infrastructure personnel will be vaccinated at regional LINCS Agency PODs in coordination with other local health departments as well as FQHCs. Acute care hospitals may also expand eligibility at their open PODs to include Phase 1b target groups beyond healthcare workers, vulnerable populations and essential workers included in Phase 1b.

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

Prioritization and Allocation:
New Jersey intends to follow the Centers for Disease Control and Prevention (CDC) framework for the broad outline of Phase 2.

While population prioritization may not be necessary once large number of doses available, scarce resource allocation may be necessary given potential for intermittent supply shortages and increasing numbers of PODS deployed statewide. Further detail on the process is provided in Section 7A.



Prioritization and allocation decisions will evolve with further clarity regarding reliability of vaccine supply and public demand.

For planning and tabletop exercise purposes and informed by limited federal and national guidance to-date, the working assumptions as preliminarily recommended by the NJDOH COVID-19 Professional Advisory Committee are listed:

Note**:** Many prioritization and allocation items remain in process.

Note: These will be validated through governmental and nongovernmental channels, and are subject to change given feedback, further information (including results of vaccine trials, additional federal guidance, and Advisory Committee on Immunization Practices recommendations), New Jersey's public health surveillance, modeling, reporting, and survey data, and other factors.

- Units of who is vaccinated: Individuals and households.
- Eligibility:
  - CDC's Phase 2 =
    - "Remainder of Phase 1 populations."
    - "Critical populations."
    - "General population."
  - Inclusive of those who live, work, and/or are educated in New Jersey.
- Sub-population prioritization criteria not anticipated to be necessary.
- May need to target allocations to align with population density and capacity to efficiently, equitably deploy scarce resources statewide.

PODS:

The number of PODS will be informed by the amount of vaccine available, the frequency of restocking, and the cold chain parameters of the vaccine(s) authorized or approved. Geospatial mapping and facility capacities (e.g. ultracold chain) will also inform which sites are established.

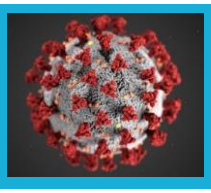
During Phase 2, NJ will scale the variety and number of PODS statewide.

- New Jersey will continue with dispensing sites at hospitals, regional/LINCS Agency PODs (and will add sites at additional LHDs and healthcare facilities, including FQHCs.
- NJ will add pharmacies as dispensing sites and will also work with large agencies (public and private) to provide on-site employee vaccinations through closed PODs.
- NJ will encourage enrollment by large medical practices and other interested private practitioners in the program.
- If needed, NJ will open one or more state sites to augment the local and regional dispensing.

C. Phase 3: Likely Sufficient Supply, Slowing Demand

Prioritization and Allocation:

New Jersey intends to follow the Centers for Disease Control and Prevention (CDC) framework for the broad outline of Phase 3.



Processes for scarce resource allocation and population prioritization will remain until there is a reliable vaccine supply. When there is sufficient supply, resource allocation can shift to routine processes, such as "as needed" disbursement. However, no determinations have been made at this time due to significant unknowns in the interim.

For planning and tabletop exercise purposes and informed by limited federal and national guidance to-date, the working assumptions as preliminarily recommended by the NJDOH COVID-19 Professional Advisory Committee are listed:

Note**:** Many prioritization and allocation items remain in process.

Note: These will be validated through governmental and nongovernmental channels, and are subject to change given feedback, further information (including results of vaccine trials, additional federal guidance, and Advisory Committee on Immunization Practices recommendations), New Jersey's public health surveillance, modeling, reporting, and survey data, and other factors.

- Units of who is vaccinated: Individuals and households.
- Eligibility:
    - CDC's Phase 3 =
        - "Remainder of Phase 1 populations."
        - "Critical populations."
        - "General population."
    - Inclusive of those who live, work, and/or are educated in New Jersey.
- Sub-population prioritization criteria not anticipated to be necessary.
- Scarce resource allocation criteria not anticipated to be necessary.

PODS:

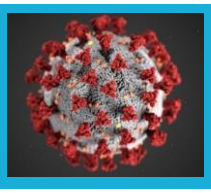
NJ will scale back dispensing sites as demand wanes and transition to routine venues for vaccine administration.

- Since healthcare workers and residents at LTC facilities and other congregate settings will have been vaccinated in prior phases, NJ will focus on regional/county LHD sites and partnerships with pharmacies and private medical practices.

However, New Jersey will used mixed methods research to assess reasons for slowing demand and may adapt response approach accordingly. Slow demand can be attributed to a multitude of causes, for example:

- Lack of trust from residents
- Lack of information to residents
- Lack of trust of the POD by residents
- Access points are barriers

A plan to overcome these and other barriers will be fundamental to implementation across phases and will be evaluated at various points of time.



Section 4: Critical Populations

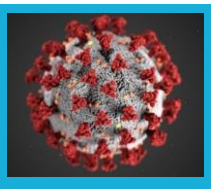
A. Critical Populations

Given CDC-informed planning assumptions that there may be limited vaccine supplies relative to demand in initial phases and that there may be insufficient vaccine available at onset to achieve community protection as well as uncertainty about the volume and reliability of resources to be provided to New Jersey's COVID-19 vaccines effort, the New Jersey Department of Health has coordinated identification, estimation, and geolocation of critical populations to inform planning, policymaking, and delivery.

a. Identification

In these preliminary planning stages, New Jersey has identified critical populations in conformance with CDC guidance. Additional critical population groupings have been identified based off other COVID-19 response activities (e.g. testing, contact tracing, etc.). Further groupings may arise based on factors such as further federal guidance, the specific eligibility criterion of any authorized or approval COVID-19 vaccines, equity considerations for planning and delivery, or operational considerations to deploy scarce resources. Subject to all applicable laws and regulations, critical populations in New Jersey include, but are not limited to:

Category	Illustrative Examples
Healthcare workers:	• Hospital workers • Long term care workers • Veteran's home workers • Home care workers • Ambulatory and urgent care clinic workers • Dialysis center workers • Dental offices workers • Morticians and funeral home workers • Pharmacy workers • Public health workers (e.g., FQHC) • Group home workers • EMS personnel • Other paid and unpaid licensed and unlicensed healthcare workers
Other essential workers in sectors that include, but are not limited to:	• First responders • Food and agriculture • Transportation • Education and child-care workers • Energy • Water and sanitation • Law enforcement • Government • Other



Adults at higher risk for severe COVID-19 due to congregate living and/or working environments, which include, but are not limited to:	• Long-term care facility residents • Adults 65 years of age or older • Adults with underlying medical conditions (diabetes, obesity, COPD, asthma, CKD etc.) • Adults who are immunocompromised • Adults incarcerated or • Adults detained in correctional facilities or county jails • Adults in homeless shelters • Adults in group homes • Adults in other congregate settings, such as adults in psychiatric institutions and migrant and seasonal farmworkers
Other Critical Populations considered high risk for COVID-19:	• People from communities that have disproportionately acquired and/or died from COVID-19 • People from tribal communities • People attending colleges/universities • People living in rural communities • People with disabilities • People who are under- or uninsured

*Note: These groups are not mutually exclusive, therefore selective double counting is expected.

b. Estimation

New Jersey's estimation of critical populations at the state and local levels is conducted by the New Jersey Department of Health. Estimates for each critical population are derived through collaboration between the New Jersey Department of Health, other state agencies (e.g. Office of Homeland Security, Department of Labor, Division of Consumer Affairs, Department of Human Services, Office of New Americans, etc.), and other external partners (e.g. employer and community groups). Estimates specific to COVID-19 vaccination planning build on data from other COVID-19 response activities.

Preliminary population sizing estimates were compiled using data sources such as, but not limited to:

- NJDOH routine and pandemic-specific data sources (e.g. health facility licensing data).
- Office of the Attorney General – Division of Consumer Affairs routine data source (e.g. licensure data for all licensed professions).
- Office of Homeland Security (e.g. Cybersecurity and Infrastructure Security Agency database maintained for New Jersey).
- Federal data sources (e.g. Centers for Disease Control and Prevention, Bureau of Labor Statistics).
- Survey data (e.g. Behavioral Risk Factor Surveillance System, American Hospital Association).

Aggregate numbers of example critical population for New Jersey are displayed in the exhibit below. These estimates used CDC Phases as detailed in the Playbook issued 9/16/2020.

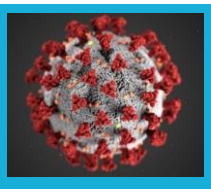


Figure 4.a.ii-1 – Population Estimates for CDC Playbook (issued 9/16/20) Phases – highly preliminary

Phase	Category	Targeted populations	CDC/CISA estimates for NJ	Timeline
Phase 1A	Health care workers with direct or indirect exposure 179,943 health care workers are over age 65 or have a chronic condition	Inpatient health care providers	175,740	**First tranche** ~83,100 doses would cover 8% of Phase 1a **Second tranche** ~831,000 doses brings Phase 1a to 91% completion **Third tranche**~1,246,500 doses completes Phase 1a and brings Phase 1b to 15% completion Combined 2,160,600 doses immunize 1,080,300 individuals, covering **12% of NJ population** *Assumes 2 doses to immunize 1 individual*
		LTC staff	94,510	
		Outpatient/home health providers	227,130	
		EMS	5,193	
		State and local public health personnel	1,067	
		Phase 1A subtotal	**503,640**	
Phase 1B	Other essential workers	Food & agriculture, transportation, education, energy, water, law enforcement, government, etc.	776,150	
	Adults with medical conditions at higher risk for severe COVID 19	Over age 65 or nursing home resident	1,509,251	
		COVID-19-relevant chronic condition (COPD, obesity, CKD, etc.)	2,551,291	
	Correcting for overlapping populations	*E.g. HCW with chronic condition, over-65 with chronic condition*	*-1,072,543*	
		Phase 1B subtotal	**3,764,149**	
		Phase 1A & B subtotal	**4,267,789**	
Phase 2	After Phase 1 complete, expand access to general population	Remaining general population	4,614,401	
		Total	8,882,190	

Sources:
Phase descriptions: CDC COVID-19 Vaccination Program Interim Playbook (Sept. 16, 2020) and playbook-cited ACIP Prioritization work group considerations
Population groups and estimates: CDC and CISA aggregation of data provided to NJ DOH Sept. 15, 2020; underlying data gathered from Bureau of Labor Statistics, US Census, BRFSS, American Hospital Assn., and others
Timelines: Combines Scenarios A & B from CDC COVID-19 Vaccination Scenarios for Jurisdictional Planning (Aug. 27, 2020), and assumes vaccines allocated by population (i.e., NJ receives 2.77%)

Preliminary, pre-decisional, and deliberative. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.

c. Geolocation

In addition to identifying and estimating critical populations, the State of New Jersey has worked across state agencies and in collaboration with external partners to locate each critical population. Information provided by State Agencies and external partners will include geographic location and mapping to help provide more granular information to inform statewide planning, to inform planning at local and county levels, and to assist local implementation partners.

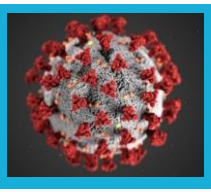
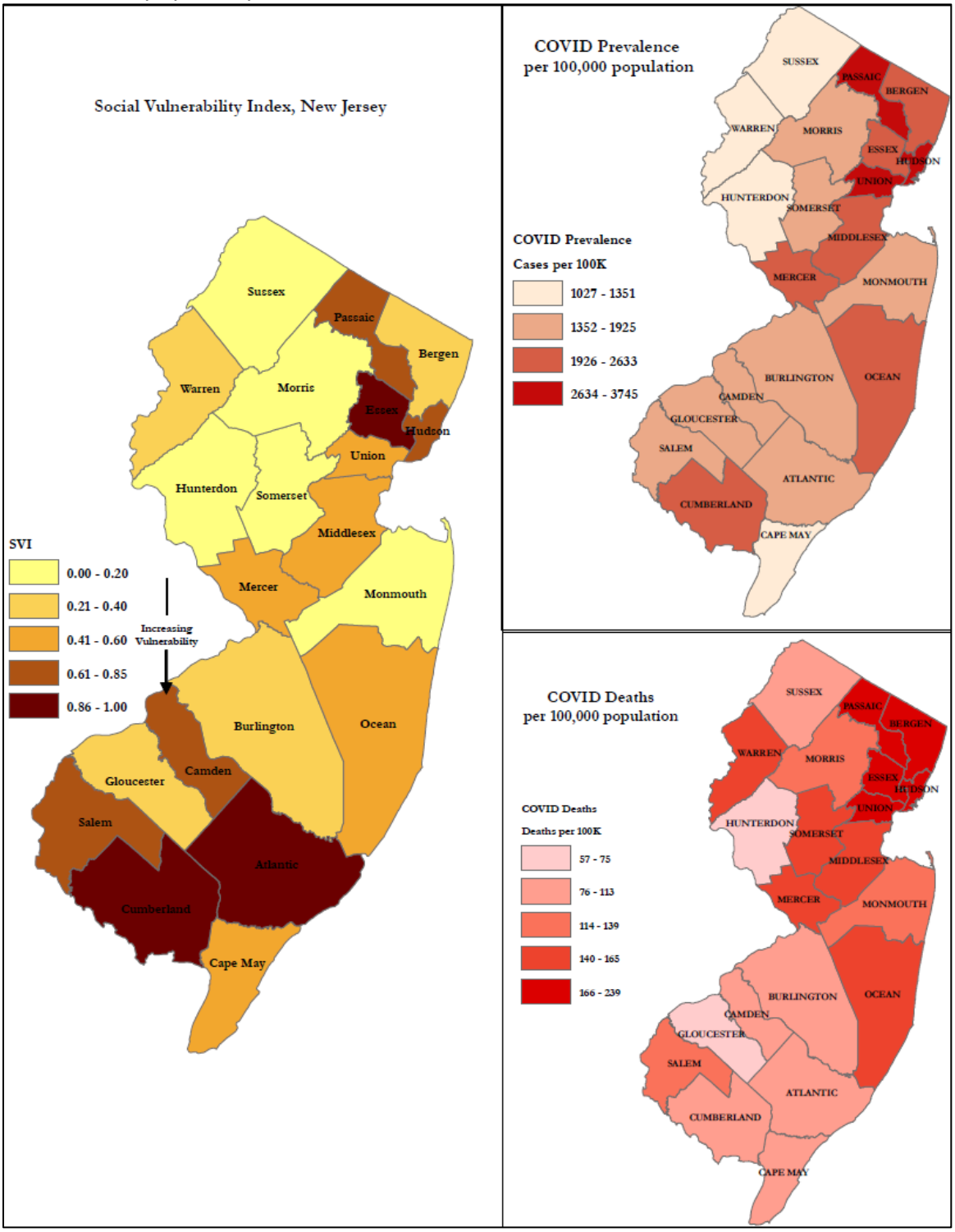
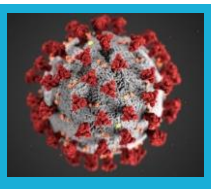


Figure 4.a.iii-1: Social Vulnerability Index by New Jersey County versus COVID-19 Prevalence by County and COVID-19 Mortality by County



Additional maps are provided in the Appendix.



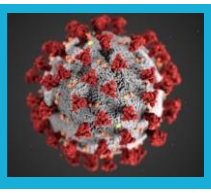
d. Definition

Figure 4.b.i-1: CISA Diagram of Essential Critical Infrastructure Workers (Source: [CISA's Guidance on Essential Critical Infrastructure Workers] issued 8/18/2020)

The State of New Jersey will work across key State Agencies and Departments to define and estimate numbers of persons in New Jersey's critical infrastructure workforce.

Definition is in-process by such groups as:

- **New Jersey Department of Health (NJDOH)**, which chairs the State of New Jersey's Coronavirus Task Force (established under Executive Order No. 102) and which coordinates in conjunction with the State Director of Emergency Management (Superintendent of State Police) the activities under New Jersey's declared Public Health Emergency and State of Emergency (established under Executive Order No. 103).
- **Office of Emergency Management (OEM)** within NJ State Police, which coordinates in conjunction with the Commissioner of Health the activities under New Jersey's declared Public Health Emergency and State of Emergency (established under Executive Order No. 103).
- **Domestic Security Preparedness Task Force (DSPTF)** within New Jersey's Office of Homeland Security and Preparedness, which coordinates the Cybersecurity & Infrastructure Security Agency (CISA) data for the state of New Jersey.



- **Economic Development Authority (EDA),** which will help reflect the differential impact of COVID-19 on industry and economics in the state of New Jersey and which co-chairs the Restart and Recovery Commission.

Further refinement of definitions may include such groups as:

- Other state agencies that may include or represent critical infrastructure workers (e.g. Department of Labor, Department of Military and Veterans Affairs, Board of Public Utilities, Department of Agriculture, Department of Community Affairs, Department of Environmental Protection, Department of Transportation).
- Other groups within and outside government.

e. Estimation

Each of the entities involved in definition are or will be involved in estimation. The preliminary definitions and estimations will be tested with key stakeholder groups, including the New Jersey Governor's Restart and Recovery Commission and the New Jersey Restart and Recovery Advisory Council.

These entities were established to bring together leaders from various industry, community, and faith-based groups and institutions across New Jersey to advise state leadership on economic issues impacted by the pandemic and to begin creating a framework for New Jersey's long-term economic recovery.

The Commission includes sub-committees focus on:

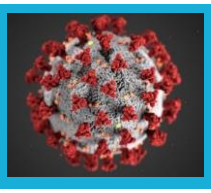
- Health
- Public & Social Services
- Economic / Fiscal

The Advisory Council's sub-committees focus on:

- Facilities and Construction
- Government
- Health Care
- Main Street
- Manufacturing and Supply Chain
- Professional Services
- Social Services and Faith
- Tourism and Entertainment
- Transportation
- Infrastructure

See Commission, Advisory Council, and subcommittees membership in the Appendix.

Highly preliminary aggregate estimates for New Jersey's critical infrastructure workforce are included in the prior sub-section of this plan. These estimates do not yet account for which critical infrastructure workers face occupational exposure versus those who can work from home, for example. In addition to adding greater definitional specificity, sub-grouping may be necessary. Such sub-groupings may be



evaluated against the risk-based criteria specified by National Academies of Sciences, Engineering, and Medicine's (NASEM) *Framework for Equitable Allocation of a COVID-19 Vaccine*:

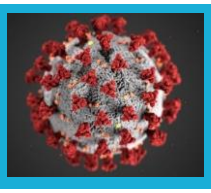
- *Risk of acquiring infection*: Individuals have higher priority to the extent that they have a greater probability of being in settings where SARS-CoV-2 is circulating and of being exposed to a sufficient dose of the virus.
- *Risk of severe morbidity and mortality*: Individuals have higher priority to the extent that they have a greater probability of severe disease or death if they acquire infection.
- *Risk of negative societal impact*: Individuals have higher priority to the extent that societal function and other individuals' lives and livelihood depend on them directly and would be imperiled if they fell ill.
- *Risk of transmitting infection to others*: Individuals have higher priority to the extent that there is a higher probability of their transmitting the infection to others.

All information being gathered for population identification, sizing, and locating will be layered with the CDC's Social Vulnerability Index as well as potentially additional indices. These indexes will be used to ensure an equity lens is applied to all planning.

B. Process to Identify Critical Population Sub-Groups, If Insufficient Vaccine Supply

Under New Jersey's Emergency Health Powers Act (N.J.S.A. 26:13-23):

> *a. [New Jersey Department of Health] commissioner shall develop and implement a New Jersey Vaccine Education and Prioritization Plan, as provided in subsection b. of this section, when the commissioner determines that: (1) an emergent condition exists and there is clear evidence that adverse and avoidable health outcomes from a preventable and acute communicable disease are expected to affect identifiable categories of high-risk individuals throughout the State; and (2) in order to protect or treat such individuals, assistance with the administration of vaccine is warranted due to a vaccine shortage.*
>
> *b. To protect the public health during a vaccine shortage, the commissioner shall issue an order to implement a New Jersey Vaccine Education and Prioritization Plan, which shall comprise:*
>
> *(1) procedures for the assessment of available vaccine Statewide;*
>
> *(2) procedures for the distribution and administration of vaccines that shall apply to physicians, nurses, health care facilities, pharmacies and others that dispense vaccines. The procedures shall include, but not be limited to, a definition of high-risk groups for priority protection or treatment in the event a vaccine shortage is imminent or existent; an*
>
> *(3) procedures for: (a) mobilizing public and private health resources to assist in vaccine distribution and administration; and*
>
> *(b) reallocating available supplies of vaccine to most effectively meet the needs of the State's high-risk groups, if necessary.*



c. As used in this section, "vaccine" includes vaccines, immune products and chemoprophylactic and treatment medications.

d. A person who willfully or knowingly violates the New Jersey Vaccine Education and Prioritization Plan or any procedures contained therein shall be liable for a civil penalty of $500 for each violation. The penalty shall be sued for and collected by the commissioner in a summary proceeding before the Superior Court pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

e. The commissioner shall notify the appropriate professional or occupational licensing board or licensing authority, in the case of a facility, of repeated violations of the procedures by a health care professional or licensed facility.

This Plan is a backbone towards establishing all of the procedures listed above.

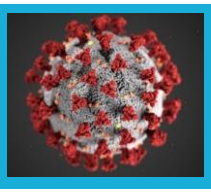
Deliberative Processes

Throughout the COVID-19 crisis, state leadership has engaged subject matter experts and thought leaders to guide New Jersey through this extraordinary and challenging time. The New Jersey Department of Health COVID-19 Professional Advisory Committee (PAC) was convened as one such forum to inform the Commissioner of Health. The Professional Advisory Committee (PAC) provides guidance to the Department to ensure that New Jersey's response to COVID-19 is based on the latest scientific, medical, ethical and public health evidence. As the scale and impact of the COVID-19 crisis has evolved, the functions and focus areas of the PAC have evolved as well. The Committee previously informed allocation of critical care resources, distribution of scarce treatment pharmaceuticals (i.e. remdesivir), and targeted population-specific testing strategies (i.e. urban communities) during this public health emergency. Since summer 2020, the PAC has reviewed federal guidance and is in process of developing recommendations for equitable vaccination population prioritization and allocation. These recommendations will be informed by subcommittees focused on health equity, community advocacy, and medical ethics and systems.

There is ongoing iterative information sharing between the PAC and the work groups mobilized within state agencies for vaccination planning and implementation. Interim recommendations have been shared with state entities and state information (e.g. data, logistics plans, etc.) is recurrently shared with the PAC to inform recommendations.

Upon receipt of the final recommendations of the NJDOH COVID-19 Professional Advisory Committee, the New Jersey Department of Health will socialize recommendations with other formal bodies and informal stakeholders to ensure diverse perspectives and a broad cross-section of New Jerseyans are integrated into planning. The ecosystem may include those listed in Section 2.

The Cabinet as mobilized through the Coronavirus Task Force has been and will continue to be deeply engaged to ensure that no constituency is unjustly left behind. Additionally, close collaboration with the Office of the Governor will persist.



Interim Planning

New Jersey intends to follow the Centers for Disease Control and Prevention (CDC) framework as outlined in the Playbook: Phase 1a and Phase 1b, Phase 2, and Phase 3.

Within the initial Phases, sub-population prioritization is anticipated given expectation of scarce vaccine availability at the onset and potential for supply shortages before vaccine manufacturing and distribution reaches scale. Sub-population prioritization and scarce resource allocation may also be needed at other times is supplies shortages arise.

Informing that sub-prioritization will include, but are not limited to:

- New Jersey-specific data, including but not limited to epidemiological, occupational, geospatial, demographic factors.
- Principles articulated by the National Academies of Sciences, Engineering, and Medicine's (NASEM) *Framework for Equitable Allocation of a COVID-19 Vaccine*, by the Johns Hopkins' *Interim Framework for COVID-19 Vaccine Allocation and Distribution in the United States*, and other public health expert guidance, data, and literature.
- Final ACIP recommendations on priority groups for each vaccine available through an EUA or traditional licensure.

New Jersey expects real-time decision-making given variability in supply and demand.

- Logistical considerations (e.g. expectation that a site must be able to administer at least 1000 doses per allotment) and experiential data (e.g. throughput of specific sites).
- Unknowns such as reliability of vaccine supply, success in provider onboarding and PODS creation, and public demand.

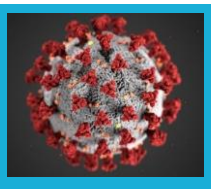
C. Process to Establish Points of Contact (POCs) and Communication Methods for Critical Population Sub-groups

Process to Establish POC

the State of New Jersey is establishing discrete points of contact for critical population groups to locate and notify potential vaccine recipients when the vaccine is made available to them.

Led by the Specific Populations Planning work group, the VTF is leveraging points of contact from prior COVID-19 pandemic response work (e.g. contacts used as part of the COVID-19 Testing Taskforce and the long-term care COVID-19 response) and existing State agency relationships.

- The list of critical populations by CDC Phase was shared with all NJDOH leadership and program staff. NJDOH personnel are collating contacts from existing grantees, boards and advisory councils, licensees, regulated entities, and other routine external partner and constituent engagement.
- This effort is expanding across state agencies to identify and establish points of contact to be able to reach critical populations. For example, the New Jersey Department of Labor has been engaged in development of this exhaustive stakeholder list.



- External partners are also involved in broadening the universe of contacts for sub-populations as defined preliminarily by the CDC Playbook (further definition in progress as explained in other plan sections).

Every internal and external agency plans to share current list of existing and new stakeholders that have been engaged prior and during COVID-19 vaccine planning. These stakeholders include, but are not limited to:

- Faith-based Organization leaders
- Community-based organization leaders
- Tribal Commissions
- Community Health Education leaders from NJSSOPHE
- Public Health academic partners

Through these channels, the State of New Jersey has developed a mapping of population category, population subcategory, organization, geographic (e.g. county or local health department region), point of contact, key group, and population estimate. Preliminary, illustrative mapping is provided in Figure 2.g.1. As more information is made available, this mapping will continue to be updated.

Communications for Critical Population Sub-Groups

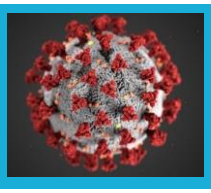
Purpose: To reduce any misinformation or concerns about the COVID-19 vaccine(s), it is important to ensure that our residents have accurate information on the benefits and risks of the vaccines(s), the priority groups to be vaccinated and the basis of the decisions why these groups were chosen, the importance of the vaccine to reduce the burden of the pandemic, and other vital information. Further detail about the ethos of COVID-19 vaccine-related communications in Section 12.

In addition to utilizing mass communications (e.g. public-facing websites, Governor's press conferences, earned and paid media, etc.), the State of New Jersey or delegated entities may engage critical population groups directly, through their places of employment or occupational professional entities, through affinity groups (e.g. older adults through AARP), through trusted community leaders, and by other creative avenues.

Illustrative, but not exhaustive examples of communication methods under consideration include:

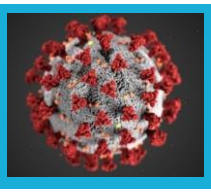
- **Partnering with employers to leverage existing technology** – For example, utilizing a wide use health network alert system for healthcare providers and staff. Healthcare systems use their text system to inform and provide next steps through smartphones. This can be done for vaccine access, shortage, dashboard on percent vaccinated, second dose reminders, and other useful information on this electronic mobile platform. Large employers' communication systems can also be utilized in the same fashion as the ones above.

- **Partnering with local government entities or community-based organizations to leverage existing notification channels** – For example, utilizing school districts (both public and private) communication systems to share vaccine information to students, parents, educators, school



staff, and school administrators. This is the same system that gives parents information on school delays, closures, events.

- **Implementing new technological solutions specific to COVID-19** – For example, NJDOH will consider whether to deploy a vaccine app to outreach, educate, remind people of first and second doses, request feedback on access, efficiency, quantity, locations of PODs, and/or etc. A NJDOH mobile app for contact tracing was launched in October 2020.



Section 5: COVID-19 Provider Recruitment and Enrollment

A. COVID-19 Vaccination Provider Recruitment and Enrollment

Types of Vaccine Providers to be Recruited

Led by the Office of the Attorney General's Division of Consumer Affairs, the State of New Jersey has identified the types of licensed health professionals qualified to administer COVID-19 vaccines. This will be continually reevaluated and potentially expanded contingent on supply and demand needs for increased vaccine administration workforce.

The current list of NJ professional licensees eligible to administer COVID-19 vaccines are listed in the Appendix.

New Jersey is pleased that New Jersey's CDC Program Officer has confirmed that a prescription will not be required for COVID-19 vaccination, even if under an EUA. If a prescription were necessary, only a limited subset of licensed professionals may issue.

Types of Settings to be Enrolled

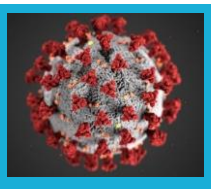
Enrollment for New Jersey's purposes includes both signing of the CDC Provider Agreement and onboarding into the New Jersey Immunization Information System.

NJDOH has a robust network of federally funded vaccine providers with over 800 VFC providers and 126 317-Funded Adult Vaccine Program providers. The current 317-Funded Adult Vaccine providers include local health departments, FQHCs and non-profit organizations.

Targeting specific providers to administer COVID-19 vaccine is determined to be the best approach, particularly in Phase 1 when supplies are limited. Using this approach will assure that all critical populations can be reached and that it can be assured that COVID-19 vaccine is being administered to the appropriate populations identified for vaccination. Recruitment of providers will be facilitated by working with current governmental agencies, professional organizations, and other vaccine stakeholders.

Initially in advance of Phase 1, the DOH is recruiting within the following provider types among those currently enrolled as 317-Funded providers (e.g. expanding number of FQHCs enrolled) and is expanding the base to include additional sites to support vaccination within Phase 1 and into Phase 2:

- **Local Health Departments** – The New Jersey Local Information Network and Communications System (LINCS) is a network of 22 strategically positioned local health departments located throughout the state of NJ. LINCS agencies will subsequently determine the Local Health Department partners in each of their 22 locations. NJDOH will also work in conjunction with them and other local and county authorities to coordinate the vaccine effort within their jurisdictions.



- **Acute Care Hospitals –** NJDOH aims to enroll the 71 acute care hospitals in New Jersey. NJDOH has a strong working relationship with the New Jersey Hospital Association (NJHA) and licenses all acute care hospitals through the NJDOH Health Systems Branch. These sites will serve as vaccination sites for the Phase 1 vaccination effort of healthcare workers and will be utilized during Phase 2 and 3 to assist with broader vaccination efforts, as needed.

- **Community Health Centers** – NJDOH will also enroll community health centers and work with the New Jersey Primary Care Association (NJPCA). There are 23 Federally Qualified Health Centers (FQHC) that operate 135 sites in neighborhoods throughout the state, including school-based and mobile sites in each of the 21 counties of New Jersey. Community Health Centers provide healthcare services to over half a million New Jerseyans annually and are uniquely posed to reach high-risk vulnerable populations. FQHCs are well represented among the VFC and 317-Funded providers. DOH has awarded 3.5 million dollars in Immunization Supplemental Funding to 10 FQHCs that are also 317-Adult providers. Through these funds, the NJDOH Vaccine Preventable Disease Program is working closely with these 10 facilities to improve their immunization infrastructure by purchasing appropriate vaccine storage units, digital data loggers, improving information technology capability, and augmenting staff. This improved infrastructure enhances their ability to immunize against influenza and to support their future COVID-19 vaccination efforts. As a condition of the supplemental funding, these sites will be hosting mass influenza immunization events during fall 2020 which will assist these facilities with developing and testing their COVID-19 vaccination plans.

- **Pharmacies** – NJDOH will onboard pharmacy providers who are not receiving direct federal shipments as needed. Further detail provided in Section 5H.

As the vaccine becomes more available, the NJDOH will identify private provider groups that serve the populations targeted for vaccination in later phases. Once the vaccine is approved for children, the NJDOH will target the existing VFC-enrolled providers for participation in the COVID-19 vaccination program. This robust network of over 800 providers is comprised primarily of private providers to which the VFC-program annually distributes 1.6 million doses for administration to VFC-eligible children.

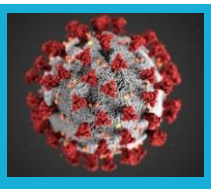
B. COVID-19 Vaccine Provider Types and Settings for First Vaccine Shipment

Types of Vaccine Providers

Provider types for the initial COVID-19 vaccine available will include healthcare professionals who have historically included provision of vaccines within their scopes of practice. Preference is for vaccine administrators who provide this service often, because confidence on the part of the provider may yield public confidence.

Types of Settings

The first vaccine doses will be administered by acute care hospitals and potentially selected LINCS agencies. The currently unknown size of the initial shipment to New Jersey will inform the number of



PODS launched at the onset. NJDOH is including scalable models that consider a range of allocations as well as costs associated with opening PODS. In order to minimize POD costs for initial shipment, NJDOH may open a limited number of regional PODs. Our local partners have already identified costs as one of the most difficult challenges in implementation of POD plans.

If we pursue a limited number of PODs initially, future PODS will partner with these sites to collaborate in building efficient and effective throughput that can be scaled as more vaccine becomes available. This model would mean that hospitals will be operating as open PODS with eligibility requirements as well as closed PODS for their own staff members.

C. Provider Enrollment Data Collection and Submission to CDC

New Jersey Department of Health is currently evaluating various solutions to determine the best mechanism for collecting provider enrollment data.

NJDOH has started integrating the provider enrollment components within NJIIS, New Jersey's state immunization registry. Technical staff will create a system to export data and submit in the CDC-provided Comma Separated Values (CSV) or JavaScript (JSON) format to CDC on a twice weekly basis, once additional guidance is provided from CDC.

D. Vaccine Administrator License Verification

NJDOH Vaccine Preventable Disease Program currently has a manual process that involves vetting the credentials of enrolling providers using online databases available through the Office of the Attorney General's Division of Consumer Affairs (OAG-DCA), the agency that licenses and regulates certain healthcare providers in New Jersey.

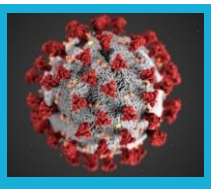
NJDOH is exploring an alternate method of vetting through OAG-DCA. The intention is OAG-DCA will electronically match providers who in enroll in NJIIS with their electronic databases and provide appropriate feedback to NJDOH.

E. Provider Training

The training and tracking of enrolled providers will use systems already in place for providers enrolled in the NJ Vaccines for Children and 317-Funded Adult Programs. At least 2 representatives from each enrolled provider site (the Primary and Back-up Vaccine Coordinator) will be required to take COVID-19 specific trainings via GotoWebinar. Additional people at each site will be trained per CDC recommendations/requirements. The webinar software provides detailed reports for registration, attendance, and completion of training. That information will be documented in NJIIS and will be available for output as required.

Training topics will include:

- ACIP recommendations



- COVID-19 vaccine ordering, receiving, storage and handling
- Inventory management
- Use of the NJIIS including data entry and interfacing
- Using NJIIS reports to review the doses administered data reported by the site
- Vaccine administration
- Management of vaccine wastage, spoilage, and temperature excursions
- Reporting adverse events to VAERS
- EUA facts sheets and/or VISs

In addition to these trainings conducted remotely, onsite training in workflow process and discrete responsibilities for each role may be offered onsite. These may occur at the beginning of each operational day, as new staff members cycle into the POD, or at another cadence as deemed necessary by the specific POD. These onsite trainings would be supplementary and are not substitutes for the statewide webinar.

F. Approval of Planned COVID-19 Vaccine Redistributions

NJIIS has the current capacity to track and approve transfers of vaccine to agencies that are currently enrolled in the system. Redistribution deliberations will be assessed and executed through collaboration across VTF workgroups. NJDOH is assessing if there are additional requirements that are not satisfied by the current system alone and will integrate those requirements as necessary.

G. Equitable Access to COVID-19 Vaccines

An example of how New Jersey is applying a quality improvement mindset is in the way we will strive to achieve equity in COVID-19 vaccination. According to the CDC, health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

COVID-19 vaccine accessibility is related to removal of barriers including, but not limited to:

- Transportation
- Process and criteria to receive vaccine (e.g., required documentation, long wait lines)
- Financial burden
- Cultural beliefs
- Limited English proficiency
- Perceptions/attitudes

Please see exhibit below an outline of how New Jersey's equity-focused quality improvement will be applied across multiple facets of the program. This list is descriptive, not exhaustive.

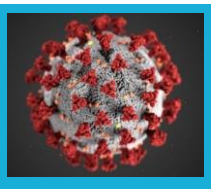
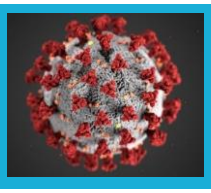
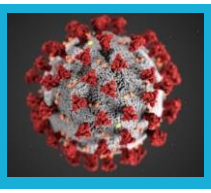


Figure 5.g.1: Leveraging quality improvement mindset to promote equity in vaccination

Organizational Structure and Stakeholder Engagement	• Incorporating diverse collaborators and perspectives in planning and delivery
	• Cultivating broad and inclusive partnerships
	• Identifying which critical population leaders and advocates should be involved in every planning phase
	• Ensuring active engagement with specific population groups and stakeholders at the planning stages from beginning to end (before first doses are made available)
	• Engaging with and planning for vulnerable populations early and often
Phased Approach	• Ensuring equitable population prioritization when resources limited (e.g. including but not limited to consideration of NASEM and JHU frameworks)
	• Enabling holistic and data-informed consideration of power, privilege, and vulnerability in prioritization and allocation
	• Ensuring equitable allocation of constrained resources given variability in available vaccines and resources
Public Confidence	• Providing transparency to foster trust
	• Partnering with strong trusted leaders for community education
	• Using conventional and innovative communications channels to connect with underserved populations
PODS Setup	• To remove transportation barriers, POD mapping, census tract mapping that includes social vulnerability indices, with distance between residence concentrations and access accountability will be taken into account. Micro-geo-mapping can ensure that there is an access point that reduces transportation barriers for all communities.
	• Ensuring COVID-19 mitigation strategies to prevent disease transmission on-site: socially distanced seating, one-way traffic flow, mandate to wear masks, hand sanitizer, and plexiglass barriers
	• Providing services during non-business hours to accommodate working families
	• Providing vaccination in safe, familiar, and convenient locations
	• Ensuring transportation accessibility (e.g. walking distance to mass transit like trains or bus, use of UberHealth, etc.)
On-site, Off-site, and Mass Communications	• To ensure diverse cultural belief respected, develop and implement focused education for diverse communities. Engaging these diverse members with stakeholder forums and conversations to understand and respect beliefs while educating on vaccine benefits.
	• Offering second dose reminders in multiple formats (e.g. digital, telephonic, written, etc.) to accommodate diverse consumers



	• Issuing informed consent, emergency use authorization (EUA) fact sheets, vaccine information statement (VISs), and other documents in culturally competent, health literate, and linguistically accessible formats. All materials and patient documents must be translated in the top 12 NJ languages and ensure interpretation services for each PODs
	• Reviewing materials through a health literacy review committee (NJ SOPHE)
	• Providing instructions and materials in the top 10 NJ languages
Staffing	• Diversifying types of vaccine administrators onboarded to provide coverage for all segments of population
	• Including in PODS staffing a patient navigator(s) who is representative of the community served
	• Including personnel who are bilingual or multilingual to ensure understanding of limited English proficiency (LEP) consumers
	• Americans with Disabilities Act (ADA) and Culturally and Linguistically Appropriate Services (CLAS) credentialing of staff, especially clinical personnel
Specific Populations Engagement	• Concerted action to alert those with limited access to information about when, where, and how to receive vaccination
	• Connecting and serving non-institution-associated subpopulations through unconventional partnerships
	• Developing tailored strategies to accommodate those with limited mobility (e.g., those in institutional settings, those with ADA needs, etc.)
Consumer Affordability	• Considering affordability options for uninsured, underinsured, and other vulnerable groups (e.g. those subject to Public Charge Rule). If a cost is associated with vaccine services, a sliding scale of state poverty criteria should supersede federal criteria.
	• Considering affordability of consumer travel to PODS in planning and delivery
Management and Administration	• Fairly compensating and resourcing of vaccine administration workforce at state, county, local, or facility-level
Enabling Policy	• Applying an equity framework to regulatory and legislative policymaking with the interest of ensuring just access
	• Removing regulatory and legal barriers that unduly constrain participation
	• Promoting expansive definitions of eligibility for vaccination, within parameters of EUA, etc.
	• Consideration of standing orders in case COVID-19 vaccine needs a prescription to facilitate access for those without primary care providers



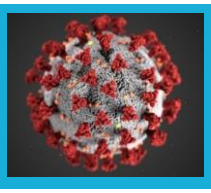
	• Equitably enforcing violations of contracts and other legal agreements
	• Refraining from instituting identity documentation requirements
Analytics and Reporting	• Tracking age, race, ethnicity, sex, sexual orientation, gender identity, insurance status, comorbidities, etc.
	• Maintaining transparency in reporting to communicate process and progress to public
	• Monitoring whether communities and individuals at increased vulnerability are provided equitable access

H. Recruitment and Enrollment of Pharmacies

New Jersey is awaiting guidance from CDC as to which pharmacies will be receiving direct federal vaccine shipments. NJDOH will onboard pharmacy sites who are not receiving direct federal shipments as needed. Licensing of pharmacists will continue to be through the Office of the Attorney General's Division of Consumer Affairs.

In anticipations of New Jersey's onboarding of pharmacies as vaccination providers, NJDOH has had discussions with representatives from key pharmacy chains. Pharmacy chains will be particularly valuable in reaching the adult population when vaccine supplies become ubiquitous. Retail pharmacies have likewise been critical in scaling COVID-19 testing in New Jersey's general population.

NJDOH will also work with the associations representing pharmacists and the pharmacy industry during this process to more easily identify pharmacies not represented by the larger chains. NJDOH has been in touch with these entities throughout the pandemic regarding testing, and NJOAG-DCA interfaces frequently with these entities through and in oversight of the New Jersey Board of Pharmacy.



Section 6: COVID-19 Vaccine Administration Capacity

A. Estimation of COVID-19 Vaccine Administration Capacity

The State is adopting "vaccine administration capacity," as defined by CDC, as the maximum achievable vaccination throughput regardless of public demand for vaccination. The State's planning assumption, therefore, is to vaccinate up to 70% of its current eligible population. This is in line with Healthy People 2030's national target for influenza vaccine uptake. We do not yet know the threshold to confer community protection ("herd immunity") for this communicable disease.

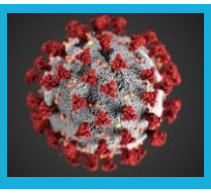
For planning purposes, current eligible population excludes those under the age of 18 and pregnant women, because these cohorts are not included in COVID-19 vaccine trials and therefore New Jersey does not anticipate that they will be initially eligible for any approved or authorized COVID-19 vaccine. New Jersey's population is inclusive of those who live, work, and/or are educated in New Jersey.

The State has developed its estimated vaccine administration capacity based on both an at-scale model (phases 2-3) and the initial phase (limited doses available) outlined in the CDC Playbook issued 9/16/2020. It has then overlaid, based on its own planning assumptions, county population, demographics, estimated populations of each identified phase, as well as the potential maximum throughput and anticipated participation of multiple POD sites, including but not limited to hospitals, FQHCs, pharmacies, urgent care centers, and government-run sites. The State has assessed throughput by vaccination setting type, incorporating factors identified in the CDC Playbook (e.g., routine immunization programs being conducted simultaneously, infection control measures). To that end, the State has developed an assumption of the average vaccination throughput needed on a daily basis if vaccinations are conducted 6 days per week for a 6-month duration. This assumption has been further broken down proportionately by county based on population. The VTF will utilize the POD site throughput estimation model that we developed in order to right-size POD planning assumptions by county, which will inform State, county, and local decision-making on the number and types of PODSs needed to achieve these goals.

B. Application of Capacity Estimates to Provider Recruitment Planning

This scenario planning has informed the State's PODS network plan that will be sequenced and implemented as scale dictates. This dynamic network plan accounts for the number, setting type, nature (e.g., closed transitioning to open), throughput, and location of the PODS that will be required in the State to deliver against its COVID-19 vaccine plan. Provider recruitment will directly follow from this PODS network sequencing plan.

The State is utilizing this information to develop a toolkit for potential PODS to include minimum site requirements based on these planning assumptions. State leadership have begun an outreach campaign to hospitals, FQHCs, pharmacies, government-run counties, and other potential dispensing providers to socialize these minimum requirements and ascertain any potential challenges that may be faced by these groups. This gap analysis will be used to help the State sequence provider recruitment and help each provider group overcome any anticipated challenges to meet throughput goals as estimated in the planning tools.



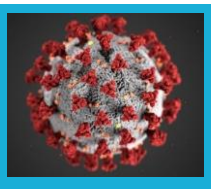
Section 7: COVID-19 Vaccine Allocation, Ordering, Distribution, and Inventory Management

A. Scarce Vaccine Allocation

Under New Jersey's Emergency Health Powers Act (N.J.S.A. 26:13-23):

> *a. [New Jersey Department of Health] commissioner shall develop and implement a New Jersey Vaccine Education and Prioritization Plan, as provided in subsection b. of this section, when the commissioner determines that: (1) an emergent condition exists and there is clear evidence that adverse and avoidable health outcomes from a preventable and acute communicable disease are expected to affect identifiable categories of high-risk individuals throughout the State; and (2) in order to protect or treat such individuals, assistance with the administration of vaccine is warranted due to a vaccine shortage.*
>
> *b. To protect the public health during a vaccine shortage, the commissioner shall issue an order to implement a New Jersey Vaccine Education and Prioritization Plan, which shall comprise:*
>
> *(1) procedures for the assessment of available vaccine Statewide;*
> *(2) procedures for the distribution and administration of vaccines that shall apply to physicians, nurses, health care facilities, pharmacies and others that dispense vaccines. The procedures shall include, but not be limited to, a definition of high-risk groups for priority protection or treatment in the event a vaccine shortage is imminent or existent; an*
> *(3) procedures for: (a) mobilizing public and private health resources to assist in vaccine distribution and administration; and*
> *(b) reallocating available supplies of vaccine to most effectively meet the needs of the State's high-risk groups, if necessary.*
>
> *c. As used in this section, "vaccine" includes vaccines, immune products and chemoprophylactic and treatment medications.*
>
> *d. A person who willfully or knowingly violates the New Jersey Vaccine Education and Prioritization Plan or any procedures contained therein shall be liable for a civil penalty of $500 for each violation. The penalty shall be sued for and collected by the commissioner in a summary proceeding before the Superior Court pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).*
>
> *e. The commissioner shall notify the appropriate professional or occupational licensing board or licensing authority, in the case of a facility, of repeated violations of the procedures by a health care professional or licensed facility.*

This Plan is a backbone towards establishing all of the procedures listed above.



Deliberative Processes

Throughout the COVID-19 crisis, state leadership has engaged subject matter experts and thought leaders to guide New Jersey through this extraordinary and challenging time. The New Jersey Department of Health Professional Advisory Committee (PAC) was convened as one such forum to inform the Commissioner of Health. The Professional Advisory Committee (PAC) provides guidance to the Department to ensure that New Jersey's response to COVID-19 is based on the latest scientific, medical, ethical and public health evidence. As the scale and impact of the COVID-19 crisis has evolved, the functions and focus areas of the PAC have evolved as well. The Committee previously informed allocation of critical care resources, distribution of scarce treatment pharmaceuticals (i.e. remdesivir), and targeted population-specific testing strategies (i.e. urban communities) during this public health emergency. Since summer 2020, the PAC has reviewed federal guidance about COVID-19 vaccine development and distribution and is in process of developing recommendations for equitable vaccination population prioritization and allocation, informed by ACIP and NASEM deliberations to-date. Recommendations for New Jersey will be informed by the pending final ACIP recommendations. The PAC's recommendations will be informed by subcommittees focused on health equity, community advocacy, and medical ethics and systems.

There is ongoing iterative information sharing between the PAC and the work groups mobilized within state agencies for vaccination planning and implementation. Interim recommendations have been shared with state entities and state information (e.g. data, logistics plans, etc.) is recurrently shared with the PAC to inform recommendations.

Upon receipt of the final recommendations of the NJDOH COVID-19 Professional Advisory Committee, the New Jersey Department of Health will socialize recommendations with other formal bodies and informal stakeholders to ensure diverse perspectives and a broad cross-section of New Jerseyans are integrated into planning. The ecosystem may include those listed in Section 2.

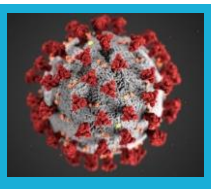
The Cabinet as mobilized through the Coronavirus Task Force has been and will continue to be deeply engaged to ensure that no constituency is unjustly left behind. Additionally, close collaboration with the Office of the Governor will persist.

Interim Planning

New Jersey intends to follow the Centers for Disease Control and Prevention (CDC) framework as outlined in the Playbook: Phase 1a and Phase 1b, Phase 2, and Phase 3.

Within the initial Phases, scarce resource allocation is anticipated given expectation of scarce vaccine availability at the onset and potential for supply shortages before vaccine manufacturing and distribution reaches scale. Scarce resource allocation may also be needed at other times if intermittent supply shortages arise, as was the case with COVID-19 testing supplies.

Informing that allocation will include, but are not limited to:



- New Jersey-specific data, including but not limited to epidemiological, occupational, geospatial, demographic factors.
- Principles articulated by the National Academies of Sciences, Engineering, and Medicine's (NASEM) *Framework for Equitable Allocation of a COVID-19 Vaccine*, by the Johns Hopkins' Interim Framework for COVID-19 Vaccine Allocation and Distribution in the United States, and other public health expert guidance, data, and literature.

New Jersey expects real-time decision-making given variability in supply and demand.

- Logistical considerations (e.g. expectation that a site must be able to administer at least 1000 doses per allotment, at least initially) and experiential data (e.g. throughput of specific sites).
- Unknowns such as reliability of vaccine supply, success in provider onboarding and PODS creation, and public demand.

B. Cold Chain Capability Assessment

NJDOH will utilize existing processes in place in NJ for VFC and 317-Funded Adult Providers to assess cold chain capacity.

Current NJIIS functionalities include:

- Information about vaccine storage units is integrated into NJIIS. Providers are required to enter information about their current storage units upon enrollment and the information is maintained within the system.
- Additionally, NJIIS currently tracks temperature monitoring data for each enrolled provider's storage units. Providers cannot place an order for vaccines if their temperature monitoring data is not current or if they indicate that their units have experienced temperature excursions. Currently, this data is only being tracked for refrigerated and frozen vaccines.

Supplementing these NJIIS-based pathways, the State is considering conducting a survey of each provider's cold chain capacity based on the guidelines established in the CDC Vaccine Storage and Handling Toolkit and the ACIP Best Practices for Immunization.

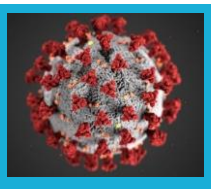
COVID-19-specific NJIIS upgrades in-process:

- The COVID-19 "provider profile," including the assessment of each provider's COVID-19 vaccine storage and handling capacity, is being integrated into NJIIS. When providers enroll in NJIIS they will be required to provide information outlining their capacity for cold chain maintenance.

Ultra-cold storage unit temperature monitoring has not been incorporated into NJIIS at this point and NJDOH will require further guidance from CDC before developing this feature.

C. COVID-19 Vaccine Ordering Procedures

DOH will utilize systems currently in place for VFC and 317-Funded Adult Program providers. Enrolled providers will place COVID-19 orders through NJIIS (as they currently do for core and influenza vaccines) and this information, along with any updated profile information (master data) and inventory data, will



be transmitted via ExIS to VTrckS. Allocation restrictions will be built into the ordering module by provider type and population served. All orders will automatically go into review status for manual review by NJDOH staff prior to transmission.

D. Unplanned Repositioning Coordination

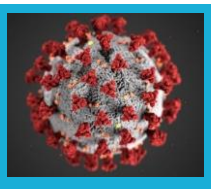
All transfers will require prior approval by the immunization program per CDC requirements. Emergency plans will be coordinated by ESF (Emergency Support Function) via New Jersey Office of Emergency Management (NJOEM). Under the State of Emergency and Public Health Emergency declared originally under Executive Order No. 103, New Jersey's State Director of Emergency Management, in conjunction with the Commissioner of the Department of Health, coordinates the relief effort for the COVID-19 emergency with all government agencies, volunteer organizations, and the private sector.

Provider sites will be responsible for the coordination of transferring doses to other enrolled sties if unplanned repositioning becomes necessary. Approval of redistributions is described in Section 5F. The Vaccine Command Center is described in Section 15D.

New Jersey will apply best practices and lessons learned from other scarce resource redistributions during the COVID-19 pandemic.

E. COVID-19 Vaccine Wastage and Inventory level Monitoring

NJIIS already has features to monitor and report vaccine wastage and inventory levels. This existing mechanism will be used to centrally and locally monitor inventory levels and to report vaccine wastage for COVID-19 vaccines as well.



Section 8: COVID-19 Vaccine Storage and Handling

A. COVID-19 Vaccine Storage and Handling Adherence

The jurisdiction will use existing mechanisms in NJIIS to collect temperature logs from each site and assure vaccines are being maintained at proper temperatures. This same process will be employed for any COVID-19 vaccines that require refrigerator/freezer temperatures. The process to assuring ultra-cold storage and handling has not been received by the jurisdiction yet. Providers are unable to place orders for vaccine if their temperature logs are not up-to-date or if their units have experienced temperature excursions.

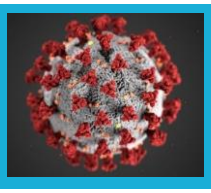
The State will rely on the guidance contained in the CDC Vaccine Storage and Handling Toolkit and this document will be shared with each provider along with the CDC-developed checklist for satellite, temporary, or off-site vaccine clinics as part of the provider site toolkit. This guidance will also set forth a description of the roles and responsibilities required for each site. One of the critical roles that each site will be required to have is a Safety and Quality Assurance Officer who will be responsible for receiving vaccine shipments, monitoring storage unit temperatures, managing vaccine inventory, etc. This individual will act in coordination with the State's program experts and their field agents to be charged with ensuring adherence and compliance to the vaccine storage and handling requirements.

The process to ensure appropriate ultra-cold storage and handling has not yet been received by the jurisdiction; once received a plan will be developed to modify to the State's PODS network plan.

B. Assessment of Provider/Redistribution Depot COVID-19 Vaccine Storage and Temperature Monitoring Capabilities

Depots will be required to report temperature monitoring data via NJIIS as any other provider would.

The jurisdiction will be extremely judicious in the use of depots for redistribution. However, this mechanism is being considered for certain circumstances and in those cases all current guidelines will be followed regarding storage and handling capabilities.



Section 9: COVID-19 Vaccine Administration Documentation and Reporting

A. System for Statewide Collection of COVID-19 Vaccine Administration Data

Currently, the New Jersey Immunization Information System (NJIIS) is the mechanism used to capture vaccine doses administered in the state, however supplemental vaccine systems (i.e. VAMS or vendor solutions) are currently being evaluated and may be used as well to capture this data.

The NJIIS can capture doses administered data by web entry via the user interface, HL7 2.5.1 interface for batch, or real-time submission (via web service) of doses administered data. The Interoperability work group is currently developing a third option, which is an Excel file in a pre-defined format that will be transformed/processed electronically in an Excel to HL7 Rhapsody route.

B. Submission of NJ COVID-19 Vaccine Administration Data Via IZ Gateway

New Jersey has completed initial connectivity to the IZ Gateway and have signed the MOU and DUA to allow for this interjurisdictional data exchange. The jurisdiction is awaiting production exchange test messages and will be ready as soon as CDC provides all requirements.

C. Provider Capacity to Report within 24 hours.

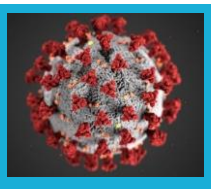
Provider enrollment in NJIIS requires each provider site to outline its capability for reporting all doses administered, including its technical capacity. Providers and staff at that location are required to take COVID-19 vaccine provider trainings, which include reporting requirements for vaccine doses administered. All reporting will adhere to the CDC reporting requirements for data and timeliness of reporting.

Adequate resourcing of PODS is necessary for any provider to be able to report in a timely manner. When estimating personnel necessary for each size of POD, dedicated data entry personnel are factored into planning. Supplies to facilitate timely and accurate data entry, including but not limited to computers or tablets should be factored into procurement planning for locally delivered vaccine PODS. Likewise, considerations for selecting the initial PODS and high throughput PODS may include presence of reliable, onsite internet access. New Jersey appreciates any federal support to defray these costs.

Quality assurance and compliance reports are currently being developed to ensure identification of non-compliant sites for outreach by NJIIS staff.

Note: Whereas the CDC Provider Agreement requires reporting within 24 hours, the current state regulation requires reporting within 30 days. Some providers have questioned feasibility of a 24-hour turnaround.

D. Real-Time Documentation and Reporting from Satellite, Temporary, or Off-Site Clinic Settings



NJIIS is a web-based reporting system and is accessible anywhere there is an internet connection to anyone with a current login.

Data reporting will be allowed via three mechanisms into NJIIS:

1. Direct entry into NJIIS: This can take place in real-time at any location with an internet connection.
2. File submission, via an Excel spreadsheet that will be translated to HL7 for upload into NJIIS: This would be a way for a location to batch submit without an interface, however will also serve as a backup if there is a loss of internet connectivity, data can be logged into the spreadsheet and then submitted through secure file transfer.
3. Use of an HL7 interface with a provider's electronic health record (EHR) system. While this will require internet connectivity, if there is an outage, once data is entered into the provider's system and the outage is resolved the data should transfer at that time.

All providers will be required to select a reporting mechanism at the time of enrollment. Onboarding for users and sites reporting via Excel or HL7 will begin after they submit their COVID-19 preliminary site enrollment forms and user agreements. These are currently available on the NJIIS website.

Additional technologies are being evaluated for large-scale vaccination sites, including the use of 2D barcode scanners for ease of data capture.

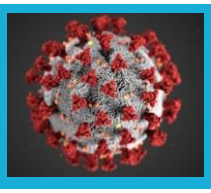
E. Documentation and Reporting Monitoring

Quality assurance and compliance reports are currently being developed to ensure identification of non-compliant sites for outreach by NJIIS staff. NJIIS technical staff are developing these reports, which will be run daily by the NJIIS QA Team Leads to assure that providers are reporting doses administered data completely and within 24 hours of vaccine administration. QA staff will be on hand to look for inconsistencies and will be working directly with providers if there are errors found.

How instances of noncompliance are managed will depend on a multitude of factors including but not limited to: degree of documentation deficiency, length of delay in data input, frequency of incomplete reporting, technological infrastructure on-hand at vaccine site, etc. Under current state regulations as of October 2020, there is a 30-day window to report into NJIIS, which creates an incongruity with the 24-hour standard established under the CDC Provider Agreement for COVID-19 vaccination.

Should NJ find an instance of noncompliance, potential state-level actions taken may include: reminders, supplemental training, corrective action planning, data entry workforce supplementation, and/or strike teams for onsite support. The State of New Jersey is not fully aware of how federal agencies will enforce noncompliance with the Provider Agreement, and the State of New Jersey is not a party to this contract at this time.

F. Generation and Use of COVID-19 Vaccination Coverage Reports



In order to monitor and guide the effective vaccination throughout the state of New Jersey, the VTF has developed a set of reporting goals. These goals, per the guidance from NASEM, "will help evaluate existing or novel theory-driven strategies and interventions to decrease COVID-19 vaccine hesitancy, increase COVID-19 vaccine uptake, and eliminate social, cultural, logistic, and legal barriers to COVID-19 vaccination in focal populations."

The State of New Jersey recognizes that there are a range of factors that can affect vaccination coverage, and therefore New Jersey's vaccination coverage reporting goals include:

- **Track vaccination status of high priority groups** – Ensure prioritization guidance is being appropriately operationalized and sufficient access for vulnerable groups is provided.

- **Support consumer navigation and second dose reminders** – Monitor effectiveness of consumer outreach and navigation and ensure consistent and comprehensive second dose reminders (where appropriate).

- **Support provider communications and training** – Ensure providers receive appropriate communication and training.

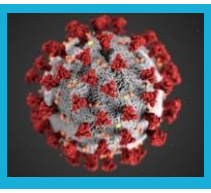
- **Ensure effective distribution and use of vaccines** – Develop approach to monitor vaccine distribution to match supply with demand and provide triggers for intervention (e.g., unplanned repositioning of vaccines as required with intent to minimize).

- **Monitor site operational efficiency and throughput** – Ensure efficient operation of sites, incorporate process improvements, and support decision making to free up or redeploy additional capacity as needed.

- **Ensure effective consumer engagement** – Build and track public perception of the COVID-19 vaccine program to drive overall uptake of COVID-19 vaccines.

The State of New Jersey is developing clear triggers and lines of responsibility should any gaps in vaccination coverage for high priority populations be identified.

Custom COVID-19 coverage reports will be generated by vaccine type and priority group. Mapping of vaccine administration will take place to provide visualization of vaccine coverage for the state by provider type, vaccine type, and population type.



Section 10: COVID-19 Vaccination Second-Dose Reminders

A. Second-Dose Reminder Methods

Providers can use existing reminder/recall mechanisms in NJIIS, however additional options are being vetted by the jurisdiction to provide expanded capability for these efforts.

Proposed additional options under consideration to engage consumers individually and/or collectively:

- **Technological solutions** – Supplemental vaccine systems, such as VAMS or other vendor solutions, are being explored to help ensure that these reminder/recall activities are optimized to bring vaccine recipients back at the correct interval and given the correct vaccine.

- **Strategic scheduling** – Fixed and mobile PODS account for two doses of the same pharmaceutical during scheduling:
    - At fixed PODS: Aim to schedule vaccination appointments approximately 21 or 28 days apart (in accordance with federal guidance about appropriate spacing of doses).
    - At mobile PODS: Schedule mobile clinics to arrive on a set cadence. Drawing upon the strategy CDC has proposed for mobile clinics for long-term care vaccination, mobile sites should plan for three visits:
        - Visit 1: First vaccine dose for all initial vaccinates.
        - Visit 2: Second vaccine dose for visit 1 attendees + First dose for those catching up.
        - Visit 3: Second vaccine dose for catch up cohort + First dose for others who missed previous opportunities (this cohort will then be referred to a nearby static site for their second dose).

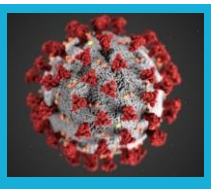
- **Hard copy distribution** – Distribution of physical vaccine card recording that the first dose was administered and with a stamp indicating on what day the patient should return for their second dose.

- **On-site and off-site Consumer Navigators** – Community-based health educators and community health workers/liaisons may also be utilized as COVID-19 vaccine navigators to remind their clients with visits and phone calls about returning for the second dose.

- **Directive on-site communication** – Signage and communication by staff at each POD to notify public about necessity of returning for second dose and indicating either when to return or how to schedule return visit.

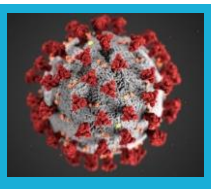
- **Targeted reminders to vaccine administrators and primary care providers** – Utilizing a wide use of the New Jersey Health Alert Network (NJHAN) for healthcare providers and staff.

- **Collaboration with identified primary care providers** – Healthcare systems and outpatient provider officers routinely use their text system to inform and provide next steps through



smartphones. This can be done for vaccine second dose reminders, and other useful information on this electronic mobile platform.

- **Partnering with employers or local entities to leverage existing notification channels** – For example, large employers' communication systems could potentially be utilized. Likewise, individual PODS may consider utilizing local school districts (both public and private) communication systems to share vaccine information. This is the same system that gives parents information school delays, closures, events.



Section 11: COVID-19 Requirements for IISs or Other External Systems

A. Contingencies for Documentation in Temporary or High-Volume Settings

In the event of a loss of power, a process for paper-based documentation will be implemented, including an immediate plan to enter data into the IT system once power resumes. Supplementary support may be provided.

B. Data Variables to be Collected

Please refer to Appendix for a highly preliminary list of variables that may need to be collected and tracked during COVID-19 vaccines rollout.

C. Current and Planned Data Exchange, Storage, and Reporting Capacity

Currently, NJIIS contains about 5 million patients, 12,150 facilities and over 73 million immunization records.

In preparation for one or more COVID-19 vaccines, the NJIIS' current IT infrastructure is being upgraded to support the anticipated increase in load and capacity. The NJIIS Technical Team is building dedicated high throughput and low latency web and API clusters. We are also increasing processing capacity in our data tier, multifold. The upgraded infrastructure will be commissioned by November 2020. The upgraded infrastructure will be commissioned by November 2020. NJIIS is working on to upgrade its Interface Management System (IMS) per the HL7 2.5.1 - CDC 1.5 specification to integrate with IZ Gateway. This will increase the availability and volume of complete and accurate immunization data stored within NJIIS.

To accommodate the immediate surge in facility enrollments that may not be compliant with HL7 2.5.1 CDC 1.5 specification, NJIIS is building an interface gateway to support such facilities by introducing an Excel reporting template option, in addition to HL7 interface. The upgraded version of IMS will be available by November 2020.

NJIIS is working on enrollment for new COVID-19 facilities and users. The pre-registration function is currently live allowing providers to begin the enrollment process by expediting the onboarding of providers to the registry and pre-registering users for COVID-19 training. The NJIIS team is also developing a COVID-19 vaccine ordering enrollment module. The vaccine ordering enrollment module is integrated into NJIIS and is entirely online. All necessary information for the COVID-19 CDC Provider Agreement will be captured.

All CDC reporting requirements will be supported as part of COVID-19 changes, including required reporting via the IZ Gateway, via VAMS, and other requirements as needed.

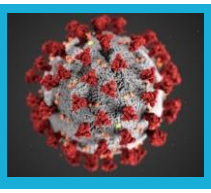
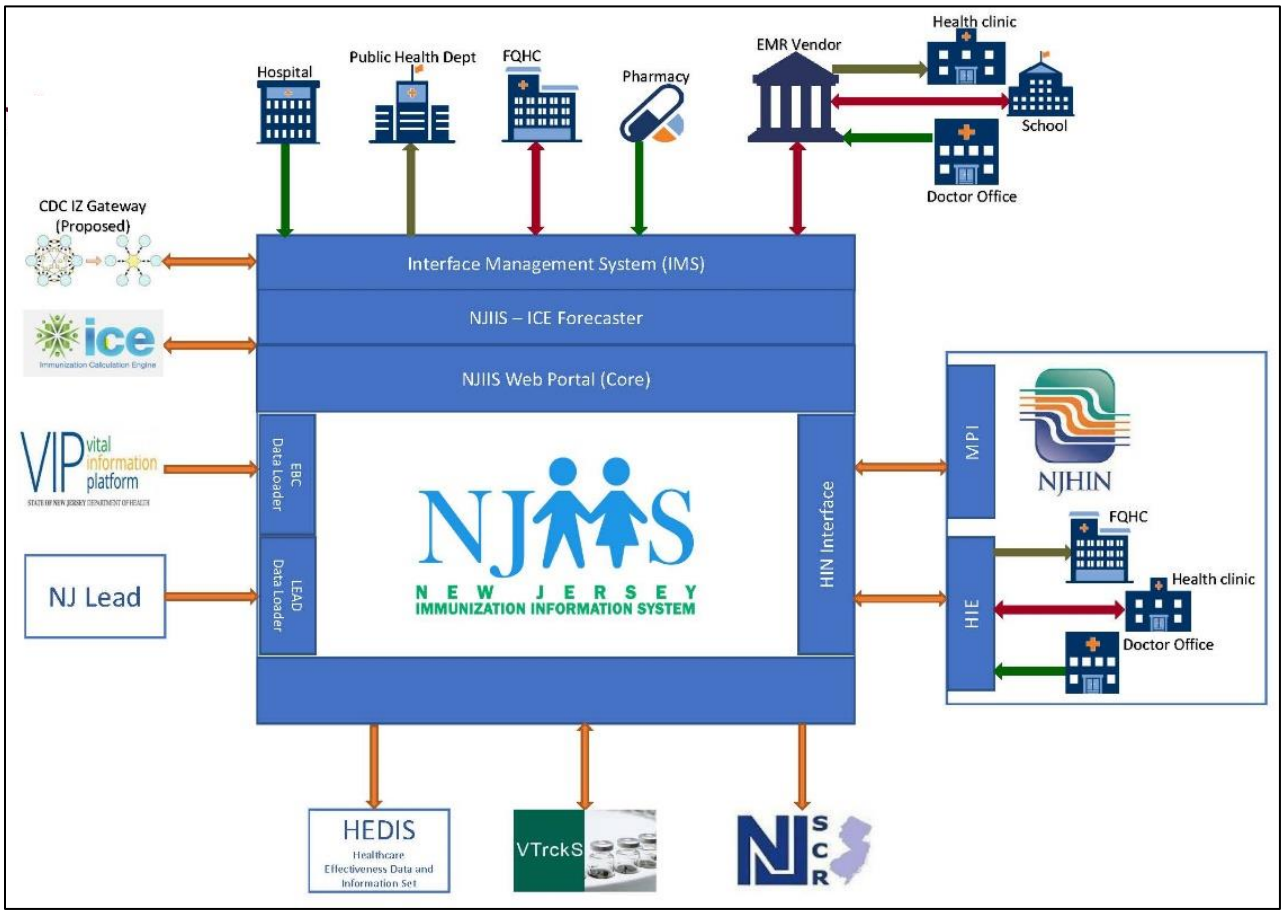


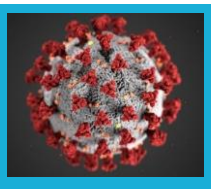
Figure 11.c.1 – NJIIS Landscape and Infrastructure Upgrades



D. Plans for Rapid Enrollment and Onboarding of Vaccination Provider Facilities and Settings Expected to Serve Healthcare Providers and Other Essential Workers

The NJIIS COVID-19 provider site pre-registration and enrollment process has been streamlined and can support rapid onboarding of the site, the users affiliated with the site, as well as the onboarding required for the selected reporting method. The process is agile and can support enrollment that will serve first tier identified populations.

Coordination between the Interoperability, Logistics & PODS Delivery, and Strategic Communications work groups, targeted outreach to acute care hospitals, to LINCS agencies, and to local health departments is already underway. Targeted onboarding outreach to other potential early vaccine sites like FQHCs is planned for near-term.



E. Onboarding to IZ Gateway's Connect and Share Components

New Jersey has successfully completed an initial test of connectivity to the IZ Gateway. The MOU and DUA documents have been signed by the required entities at NJDOH. The NJIIS technical team is prepared to commence testing data submission via the IZ Gateway whenever required.

F. Status Updates

i. IZ Gateway DUA

New Jersey's data use agreement with the Association of Public Health Laboratories to participate in the IZ Gateway was signed and submitted as of 9/28/2020.

ii. CDC DUA

The jurisdiction is waiting for the data use agreement with CDC for national coverage to be sent from CDC.

iii. IZ Gateway Share MOU

New Jersey's Memorandum of Understanding to share data with other jurisdictions via the IZ Gateway Share component was signed and submitted as of 9/28/2020.

G. Planned Backup Solutions for Offline Use if Lack Internet Connectivity

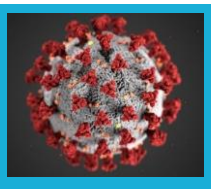
The backup mechanism for submission when there is no internet connectivity is to collect data in a preformatted Excel spreadsheet that can be sent to the State via secure file upload and translated into HL7 messaging to be uploaded into NJIIS. For providers with an electronic interface it is expected that as soon as internet connectivity is reestablished the data will be transferred via that mechanism.

If there is a long-term outage, the provider would work with NJIIS technical staff to assure data would be sent in the appropriate timeframe.

If NJDOH experiences a loss of internet connectivity and NJIIS is down, data received via Excel or HL7 will be held in queue until the system is back up, at which time data will begin processing.

H. Data Quality Monitoring

NJIIS has existing quality assurance checks in place for reporting via user interface as well as via HL7. The jurisdiction plans to bring on additional Quality Assurance staff to ensure an adequate capacity of individuals to review submissions for completeness, accuracy, and timeliness of reporting. Currently, QA reports are in development to validate the elements of doses administered data from provider sites and enable the QA team to evaluate submissions. A protocol will be established whereby reports are generated, reviewed, and noncompliant sites will be outreached to ensure daily reporting.



Section 12: COVID-19 Vaccination Program Communication

A. Interim COVID-19 Vaccination Communications Plan

i. Overarching Approach

Building public confidence in safe and effective COVID-19 vaccine(s) is a complex challenge—especially in New Jersey, where there is a vocal anti-vaccine movement. And, like other states, there is historical mistrust in government-sponsored vaccination among some communities of color that must be overcome with strategies tailored to specific populations.

Credible and consistent health communication messaging will be shared through multiple strategies and across multiple media platforms to address the concerns of specific audiences using timely and science-based public health and medical information from trusted sources. All messaging, infographics, FAQs, call center scripts, websites and other resource material that is disseminated to the public and stakeholder groups will be culturally appropriate and translated into multiple languages.

To accomplish this, the Department developed and is executing a stakeholder engagement plan with three objectives:

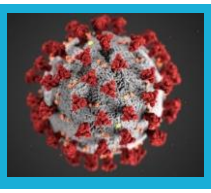
- Build trust among state, local public health, vaccine providers, and recipients of vaccines
- Understand how to ensure ease of access to the vaccine, and to information about the vaccine
- Cultivate a network of diverse partners—including trusted community thought and opinion leaders—committed to safe, accessible COVID-19 vaccine.

Engagement will increase trust and support among populations prioritized for vaccination including health care and essential workers; individuals with co-morbidities; those 65 and older; underserved minority populations and others at highest risk of serious complications from COVID-19; individuals who have experienced historical vaccination traumas; and individuals who can build bridges to these populations, either by providing the vaccine themselves or by recommending it and forming connections with trusted providers. Transparency into any allocation process and future vaccine availability will be provided to the public.

Stakeholders are being engaged for three purposes:

- **Awareness** of the current pandemic situation in the state and state planning efforts for a large-scale vaccination plan
- **Education** of stakeholders and the public of the process for approval of the vaccine(s) and communicate that although the timeline is accelerated, that the safety checkpoints are in place. Safety is a guiding principle for the Advisory Committee on Immunization Practices.
- **Action-**Arming stakeholders and the public with accurate, up-to-date scientific facts they need to make the best decisions for the health and safety of themselves and their loved ones.

An engagement tracking tool described in the following exhibit has been developed to ensure that all appropriate groups are engaged during development of the State's COVID-19 vaccine rollout plan. This tool and groups that will be engaged are described in the Appendix.



ii. Phase 1: Potentially Limited Doses Available

Timely public health and science-based vaccine information will be disseminated regularly by and through well-established public health channels including the NJLINCS agency Health Educators/Risk Communicators and professional organizations including the Medical Society of New Jersey, the New Jersey chapter of the National Medical Association, the New Jersey State Nurses Association, the New Jersey Hospital Association, the New Jersey Primary Care Association and the New Jersey COVID-19 Professional Advisory Committee and its Health Equity Subcommittee.

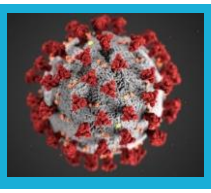
Other crucial channels for disseminating information include the New Jersey COVID-19 Information Center; 2-1-1 call and text COVID to 898-211); and the New Jersey Poison Center Call Center (1-800-222-1222/Text: 973-339-0702).

State and stakeholder social media platforms will also be used as trusted sources of information dissemination. The twitter account of Governor Phil Murphy has 340,600 followers and has won national awards. Other social medial platforms that will continue to be used throughout the pandemic include those of the New Jersey Department of Health; sister state agencies; the state's congressional and legislative delegations; county executives, the Urban Mayors Association; New Jersey League of Municipalities; the New Jersey Hospital Association and other partners outlined in the stakeholder engagement below).

During the phases of the vaccine rollout, in accordance with the equitable COVID-19 vaccine population prioritization, and in line with EUA parameters, high-profile individuals in New Jersey who choose to be vaccinated will be administered the vaccine publicly in the interest of building public trust. These may include such individuals as Governor Murphy, NJDOH Commissioner Judith Persichilli, NJDOH Deputy Commissioner for Public Health Services Dr. David Adinaro, members of the Cabinet of New Jersey, NJDOH COVID-19 PAC members, healthcare leaders serving historically vaccine skeptical communities, etc. Disadvantaged communities must see that people in power and influence are getting the vaccine to communicate that this is a safe thing to do and will help to protect the individual and the community.

A statewide public awareness campaign will be tailored in Phase 1 to health care personnel--organizations and clinicians who will receive information about receiving and administering the vaccine—and workers in essential industries. The New Jersey COVID-19 Professional Advisory Committee and its subcommittees are charged with recommending what subgroups of priority populations should be considered under various scenarios of limited does amounts. Messaging will explain to those who are prioritized for initial phases why they should participate, and to reassure those who are not provided this early opportunity why they can trust that the prioritization and allocation are equitable.

Messages will emphasize the safety and efficacy of available COVID-19 vaccine(s) based on reviews of data from vaccine trials and ACIP recommendations as well as the need to protect themselves, their families, their patients and customers and their community. These messages are being developed based in part based on feedback from a series of key informant interviews/listening sessions/surveys with key stakeholder groups that began in September.



Physicians and nurses have strong trusted relationships with their patients and will be pivotal in influencers in building public confidence in any vaccine deemed safe and efficacious by the federal government and the ACIP. According to a national poll conducted in late September, 57% of New Jersey respondents said their physician will be the most important influence on whether they get a vaccine when it becomes available.

The Medical Society of New Jersey, the New Jersey Hospital Association, and the New Jersey Nurses Association are polling membership about attitudes about COVID-19. The PAC will review data from clinical trials and the National Medical Association formed an independent advisory committee—with New Jersey representation—to evaluate data from clinical trials. The potential for groups like the National Medical Association to enhance community confidence through independent scientific review of clinical trial data will be extremely important to address concerns that lack of data transparency will undermine trust.

To build confidence among parents and the boarder community, providers and other health care professionals will be provided effective information resources through the NJ COVID-19 Innovation Hub, the Department website, NJLINCS agency Health Educators/Risk Communicators, the PAC, and various professional organizations.

The messages would include:

- Updated talking points/call center scripts
- Coordinated social media messages
- Newly developed educational materials/infographics/fact sheets as needed to convey key vaccine messages regarding target audiences, safety, credible information sources, etc.
- Flu vaccine (required among health care providers in New Jersey this year for the first time) material

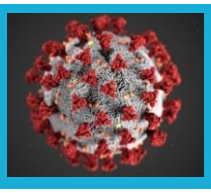
iii. Phase 2: Large Number of Doses Available, Supply Likely to Meet Demand

As vaccine doses become more plentiful, communities, especially those disproportionately impacted by COVID-19, must be effectively, authentically, and meaningfully engaged in local vaccination plans. As a result, messaging will be shared with strong community partners like the four regional health care hubs—which participated in the Public Confidence workgroup's listening sessions and focus groups (see *Exhibit III* for details)—will help the Department build public confidence in the vaccine.

Testimonial PSAs will also be sought from survivors in the community—or those who lost loved ones—coupled with a positive message about ending the pandemic together to build support. The Department has already successfully deployed this messaging during three previous pandemic public awareness campaigns: The Department's *For Each Other For Us All* testing and contact tracing campaign, which began over the summer; the COVIDNJ Alert App which launched October 1; and the statewide flu campaign. The theme of this year's *Power to Protect NJ—Against the Flu.*

Communication to the general public will also include:

- Updated talking points/call center script



- Coordinated social media messages
- Newly developed educational materials/infographics/fact sheets as needed to convey key vaccine messages regarding target audiences, safety, credible information sources, etc.
- Feedback from key informant interviews/listening sessions/surveys likely to be effective in fostering public confidence especially among vulnerable populations
- Messages disseminated among established channels including the LINCS agencies Health Educators/Risk Communicators and various professional organizations

iv. Phase 3: Likely Sufficient Supply, Slowing Demand

As enough vaccine becomes available and demand slows, it will be increasingly important for outreach at the community level through a statewide public awareness campaign. The campaign will include trusted public health officials and respected local religious and community influencers, but it will also amplify the voices of local survivors in the community and those who have lost loved ones. The campaign will use videos and PSA testimonials to make a connection between the 200,000+ people lost during the pandemic, and those who are still suffering long-term effects of COVID-19.

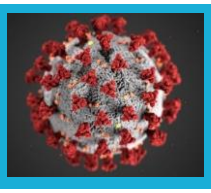
Communication to the public will also include:

- Updated talking points/call center scripts
- Coordinated social media messages
- Newly developed educational materials/infographics/fact sheets as needed to convey key vaccine messages regarding target audiences, safety, credible information sources, etc.
- Posting of video PSA's from health officials to emphasize the importance of everyone getting a vaccine.
- Messages disseminated among established channels, including the LINCS agencies, health educators/risk communicators, and various professional organizations.
- Feedback from key informant interviews/listening sessions/surveys likely to be effective in fostering public confidence especially among vulnerable populations.

B. Risk, Crisis, and Emergency Communications

Using our public awareness campaign and the tools outlined in the three phases of vaccination (updated talking points/updated call script/infographics/fact sheets), we will ensure that the New Jersey NJCOVID-19 Information Hub; the state government and Department websites; and social media channels of the state and stakeholders contain effective and evidenced-based messaging.

As new information becomes available the Department will continually update messaging (talking points/call center scripts) and provide that information immediately to 211, the NJ PIES Call Center, the New Jersey COVID-19 Information Center and post it to the Department website and social media platforms.



As New Jersey has done throughout the pandemic, Governor Murphy, Health Commissioner Judith Persichilli, State Police Superintendent Patrick Callahan, and Homeland Security Director Jared Maples will provide regular updates as warranted.

Newly developed educational materials/infographics/fact sheets will be disseminated among established channels including the LINCS agencies Health Educators/Risk Communicators and various professional organizations as needed to convey key vaccine messages regarding target audiences, safety, credible information sources, etc.

The Department will use these educational materials/infographics to communicate important information to specific audiences such as the younger population, doctors, schools, etc.

In addition, coordinated social media messages will be sent by the Office of the Governor; the New Jersey State Police Office of Emergency Management; the Governor's Restart and Recovery Commission; the PAC and its subcommittees; as well as all of the social media platforms of local, state sister agencies and stakeholders.

The New Jersey Department of Health uses 3 social media platforms including Facebook, Twitter and Instagram—with a total of 100,000 followers—to rapidly push out relevant information and to dispel myths, misinformation and misreporting of scientific evidence misinformation as it pertains to COVID-19.

We know that negative vaccine perspectives are very common on social media and can cause vaccine hesitance among other social media users.

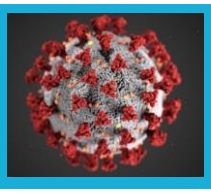
The Department can engage social media users using Question and Answer sessions which have proven to be effective in the past. This will allow users to communicate their concerns directly to our health officials directly.

This effort began in the summer with the Department's For Each Other For Us All testing and contact tracing campaign and later its COVIDNJ Alert App which launched October 1. Commissioner Persichilli filmed a video PSA to urge participation in the COVIDNJ Alert App.

Since the end of the Department has also used its social media platforms to encourage people to get vaccinated against flu protect themselves and prevent a drain on medical resources with the likely "twindemic" of flu and COVID-19 like illness. The statewide flu campaign, *Power to Protect NJ—Against the Flu*, began October 1.

In addition, the Department will use video PSA's from health officials to emphasize the importance of everyone getting a vaccine. Commissioner Persichilli got a flu shot at her neighborhood Walgreens and a video was posted on social media to encourage statewide vaccination.

The Department will collaborate with other health agencies including the CDC, HHS, county and local health departments and all the groups outlined in our stakeholder engagement plan to reshare relevant information.



i. Listening Session Plan

In anticipation of COVID-19 vaccine availability, New Jersey Department of Health (NJDOH) will increase stakeholder engagement including focus groups, listening sessions and key informant interviews.

Objectives

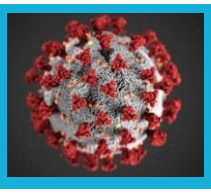
- Build trust between the State, local public health, vaccine providers, and recipients of vaccines
- Understand how to ensure access to the vaccine and clear, aligned information about the vaccine
- Cultivate a network of diverse partners committed to safe, accessible COVID-19 vaccination

Engagement will seek to increase trust and support among populations prioritized for vaccination, such as healthcare and other frontline workers, as well as individuals with co-morbidities; individuals who have experienced historical vaccination trauma and/or come from marginalized communities; and individuals who can build vaccination bridges to these populations, either by providing the vaccine themselves or by recommending it and forming connections with trusted providers and accessible conditions.

Strategies

The following strategies aim to elicit information quickly to support the vaccination planning process, while relying on partners with existing relationships with communities critical to ensuring safety, equity and trust:

- NJDOH and/or partners is conducting focus groups, listening sessions and key informant interviews. The first sessions are being conducted with those who have begun to discuss the complexities of COVID-19 vaccination with their communities, including:
    - Healthcare providers that serve priority populations or marginalized communities
    - Local Health Departments and/or their local partners
    - Community-based organizations and Community Advisory Boards
    - Community Leaders, including faith leaders and local officials
    - Public health practitioners and health educators
- In addition, NJDOH will disseminate focus group tools to stakeholders across the State, including facilitation guide, data entry/notes template and vaccination talking points, and a mechanism for reporting data back to the Department and sharing insights with the State's vaccination task force.
- Draft questions/probing questions were developed for: (1) Healthcare providers and potential vaccine providers; (2) Vaccine Ambassadors and/or "Connectors" (e.g., elected officials, community-based organizations, faith leaders); and (3) Vaccine recipients. NJDOH asks partners engaging their communities to edit and adapt the questions as they see fit.



Section 13: Regulatory Considerations for COVID-19 Vaccination

A. Provider Awareness, Access, and Understanding of Emergency Use Authorization (EUA) Fact Sheets and Vaccine Information Statements (VISs)

Awareness

All providers will be made aware of the conditions and information outlined in the EUA fact sheets at the time of their required COVID-19 training, prior to the completion of enrollment as a COVID-19 vaccine provider. If the information is not available at the time of the training/enrollment, providers will be informed that the information is forthcoming and will be made available to providers electronically (e.g., posting on NJIIS sites, email to enrolled providers) In addition, information about the need to provide an EUA-approved fact sheet or Vaccine Information Sheet (VIS) is included in CDC's Provider Agreement which must be signed by the provider as a condition of participation.

Access

In addition to providing access to the EUA and/or VIS documents, as applicable, during onboarding and any supplemental training, tactics to provide access to these documents may include:

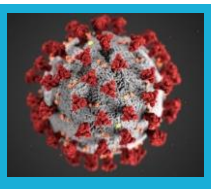
- Distribution from the manufacturer with vaccine shipment
- Posting to public-facing and vaccine provider-specific websites;
- Direct or mass emails to providers enrolled as COVID-19 vaccine administrators;
- Mass emails to potential vaccine providers in collaboration with the Office of the Attorney General's Division of Consumer Affairs, responsible for licensed professionals;
- Incorporation in signage at PODS (contingent on scarce resources);
- Distribution in hard copy at PODS (contingent on scarce resources);
- Circulation through mass media.

Meanwhile, the diversity of New Jersey's vaccination workforce must be accommodated through the provision of EUA, VIS, and other key documents in common New Jersey languages including Spanish, Chinese, Arabic, Haitian Creole, Polish, Mandarin, Hindi, Portuguese, Korean, Gujarati, Vietnamese, Yiddish, Russian, and Filipino-Tagalog. New Jersey has requested federal provision of expert translation of these vital documents.

Understanding

Potential tactics to monitor understanding may include:

- Spot checks for quality assurance;
- Hosting of forums for providers to ask questions about these documents;
- Comprehension assessments associated with trainings.



B. Vaccine Recipient Awareness, Access, and Understanding of EUA Fact Sheets and VISs

Awareness

Trainings required for all COVID-19 enrolled providers will outline the need to provide EUA fact sheets and/or VIS statements to each vaccine recipient prior to vaccine administration. In addition, information about the need to provide an EUA-approved fact sheet or VIS is included in the CDC's Provider Agreement which must be signed by the provider as a condition of participation.

Access

Tactics under consideration for how to provide vaccine recipient direct access to EUA Fact Sheets and VISs include:

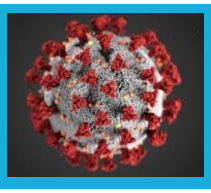
- Posting to public-facing and vaccine provider-specific websites;
- Incorporation in scheduling process and/or reminder communications;
- Incorporation in signage at PODS (contingent on scarce resources);
- Distribution in hard copy at PODS (contingent on scarce resources);
- Circulation through mass media;
- Discussion by officials in public forums like the Governor's recurrent COVID-19 press conferences.

Meanwhile, the diversity of New Jersey's vaccination population must be accommodated through the provision of EUA, VIS, and other key documents in common New Jersey languages including Spanish, Chinese, Arabic, Haitian Creole, Polish, Mandarin, Hindi, Portuguese, Korean, Gujarati, Vietnamese, Yiddish, Russian, and Filipino-Tagalog. New Jersey has requested federal provision of expert translation of these vital documents. Recognizing disparities in health literacy, documents should be in accessible reading level.

Understanding

Potential tactics to monitor understanding may include:

- Availability of personnel at vaccine sites to answer questions or clarify documents;
- Hosting of forums for public or subpopulations to ask questions about these documents;
- Encouragement of primary care providers (PCP) to counsel own patients on EUA Fact Sheet and VISs in advance of vaccine visit scheduling.



Section 14: COVID-19 Vaccine Safety Monitoring

A. Vaccine Adverse Event Reporting System (VAERS) Requirements and Process

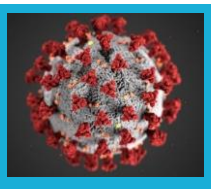
The Vaccine Adverse Event Reporting System (VAERS), is a national program managed by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) to monitor the safety of all vaccines licensed in the United States. VAERS collects and reviews reports of adverse events that occur after vaccination. An "adverse event" is any health problem or "side effect" that happens after a vaccination. VAERS cannot determine if a vaccine caused an adverse event, but it can determine if further investigation is needed.

VAERS is a passive reporting system, meaning it relies on individuals to send in reports of their experiences. Anyone can submit a report to VAERS, including physicians, guardians and patients. Individuals wanting to submit information on an adverse event are encouraged to report the adverse event online, directly though the VAERS website: https://vaers.hhs.gov/reportevent.html.

Information about the requirement to report to VAERS will be included in the mandatory training for providers enrolled in the COVID-19 vaccination program. The NJDOH VAERS Coordinator will develop and distribute information about reporting vaccine adverse events and administration errors related to the COVID-19 vaccine to NJ healthcare providers/facilities and public health partners. This will serve as a reminder of vaccine-related events that healthcare providers must report to VAERS, and steps/information needed for reporting to VAERS. These messages will be distributed widely through NJ's Health Alert Network (LINCS) and other collaborating agencies such as the OAG Division of Consumer Affairs, which is responsible for licensing and regulating healthcare providers in NJ.

Anyone who calls NJDOH through a forthcoming designated consumer call center regarding an adverse event related to a COVID-19 vaccine will be transferred to the VAERS Coordinator and/or others trained to accept the reports. The VAERS Coordinator will provide reporting information to the caller and refer them to the VAERS website. If the caller is unable or unwilling to report online through the VAERS website, the VAERS Coordinator will obtain necessary information from the caller and submit the report to VAERS on behalf of the caller through the online reporting form.

VAERS will begin sending unredacted adverse event data for the COVID-19 vaccine on a weekly basis to states via Epi-X. This information will be retrieved by the VAERS Coordinator, or designee, on a weekly basis and will be compiled in a password-protected file on a secure shared drive on the NJDOH server. Anyone who has access to unredacted adverse event data on Epi-X, or who is given access to the secure shared drive, will have to read the NDA that was compiled by VAERS, and then sign an Acknowledgement from NJDOH that will be kept on file by the data steward.



Section 15: COVID-19 Vaccination Program Monitoring

A. Methods and Procedures for COVID-19 Vaccination Program Implementation Monitoring

Please note: New Jersey has requested a Tiberius Analytic Support subject matter expert embed. This person would ensure that NJ is optimally using the data available through Tiberius and other federal systems to monitor vaccination efforts, inform programmatic activities, and meet the federal reporting metric requirements.

i. Provider Enrollment

The jurisdiction will perform data exports daily (or at a frequency prescribed by CDC) of COVID-19 vaccine providers enrolled in NJIIS to track provider enrollment.

ii. Access to COVID-19 Vaccination Services by Population in All Implementation Phases

The jurisdiction will use data from all relevant data sources (e.g. NJIIS, VTrckS, and other on-site surveys). Data exports will be performed at a frequency prescribed by CDC and in response to reporting needs that emerge for the state to monitor progress and impact.

iii. IIS and/or Other Designated System Performance

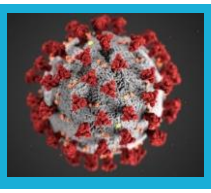
The NJIIS Technical Team will routinely monitor system performance using a variety of available technical tools. As technical infrastructure is enhanced and periodically, the system will be pressure tested to evaluate performance with respect to user interface/experience, electronic interface (HL7) processing, and database performance. The NJDOH Health Information Technology office, which hosts and maintains NJIIS, will work closely with the State Office of Information Technology and be able to leverage additional tools and support from OIT as needed to assess performance and rapidly troubleshoot any issues.

iv. Data Reporting to CDC

Relevant data will be transmitted electronically via secure interface via the IZ Gateway, SAMS (provider site lists), and other required mechanisms. Transmissions will be constantly monitored to ensure success of all reporting initiatives.

v. Provider-Level Data Reporting

The jurisdiction will perform NJIIS exports daily and as needed that will include provider-level data reporting variables. These will be used to track success of the provider in administering the received doses, and compliance with reporting of doses administered data.



vi. Vaccine Ordering and Distribution

The jurisdiction will perform exports daily and/or as needed from VTrckS and NJIIS data to monitor vaccine ordering, distribution, wastage, and storage and handling issues.

vii. 1st and 2nd Dose COVID-19 Vaccination Coverage

The jurisdiction will perform exports (at a frequency prescribed by CDC) of NJIIS data to monitor 1- and 2-dose coverage. NJIIS currently uses the Immunization Calculation Engine (ICE) for vaccine dose evaluation and forecasting. Once ICE enhancements for COVID-19 are implemented, New Jersey will integrate those changes to our forecasting and scheduler. Appropriate forecasting of second doses will be enabled via NJIIS, and via interface for HL7 bidirectional enabled data exchange sites. Those sites will be able to submit a Z44 QBP message and receive a Z42 RSP with forecasting. Additionally, peripheral systems are currently being evaluated and may be utilized to remind patients regarding second dose scheduling.

B. Methods and Procedures for Resource Monitoring

i. Budget
ii. Staffing
iii. Supplies

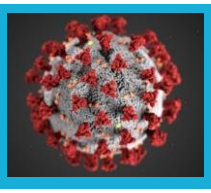
The State will conduct regular check-in meetings with all local jurisdictions on at least a weekly basis to monitor human and physical resources dedicated to the implementation of the State's vaccination plan. The State, in its planning process, is working to create operational efficiencies and establish contingencies to mitigate any potential resource gaps. The State has various contracts in place which can allow the purchase of needed supplies and also allow for the provision of contracted staffing services. Additionally, pursuant to State procurement law (N.J.S.A. 52:34-6.2 and N.J.S.A. 40A:11-12), political subdivisions of the State may participate in the State's Cooperative Purchasing Program, which allows counties and municipalities to leverage existing State contracts for goods and services.

All resource requests from providers will be processed through the well-established emergency management system. Providers will contact local and County OEMs, with needs which will then be reviewed and processed through State OEM. Given the uncertainty of future funding streams to support implementation of the State's vaccination strategy, the State anticipates that any funding received would be proportionately distributed to counties and factor in each county's ability to maintain compliance and throughput at each vaccination site.

C. Methods and Procedures for Communications Monitoring

i. Message Delivery
ii. Communication Messages/Materials Reception Among Target Audiences

The COVID-19 pandemic has been full of communication challenges unlike any other public health response to date. Not only has this been a worldwide pandemic, but one that has been caused by a novel strain of a virus that was relatively unknown to most people, a coronavirus. As these situations unfold the medical community builds its body of knowledge regarding the virus, its transmission, the scope of



illness it creates, and the best practices in treatment. These things take time and recommendations change which can cause members of the public to lose trust in public health officials.

Countering misinformation daily has been a significant challenge throughout, and social media makes this a difficult task. However, NJDOH will continue to provide public information based on the most current, updated and science-based data so that our constituents can take that information and make the best decisions for the health and safety of themselves, their loved ones, and their communities.

The first step in bolstering public confidence is to learn the attitudes and beliefs among our target audiences. The Department is currently exploring ways to better understand any potential barriers to receive the COVID-19 vaccine among those who can most benefit from it. Once we identify the barriers, we will devise strategies to overcome them and, and craft targeted communication messaging.

To understand and inform public expectations of COVID-19 vaccine risks, benefits, and supply, NJDOH is seeking insights from focus groups run by external partners (e.g. hospitals that engaged communities around COVID-19 vaccine trials) and investigating how to conduct additional focus groups as NJDOH or through academic, regional health hubs, or community-based partners.

Would a rushed approval affect willingness of people to get the vaccine?

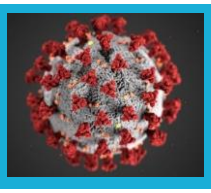
The key is to inform the public of the process for approval and communicate that although the timeline is accelerated, that the same safety checkpoints are in place. Safety is a guiding principle for the Advisory Committee on Immunization Practices that makes the recommendations on the use of the vaccine(s).

How do we engage pro/anti/hesitant vaccine communities?

New Jersey has what may be the strongest, most vocal anti-vaccine communities throughout the state, but not everyone who has concerns should be considered an “anti vaxxer.” Vaccine-hesitant individuals are a heterogeneous group who hold varying degrees of indecision about specific vaccines or about vaccinations in general. Vaccine-hesitant individuals may accept all vaccines but remain concerned about them; they may refuse or delay some vaccines but accept others; or they may refuse all vaccines. Each of these groups requires different approaches when discussing vaccines and generally respond with different levels of success.

The first step in addressing antivaccine sentiments, is to prioritize community engagement. By talking to community leaders and a cross section of the public who represent the diversity of our State, we can begin to have a dialogue to better understand their concerns and beliefs so that we can provide targeted information to allay these hesitancies. We hope to engage these communities through both our internal and external stakeholders. Through these collaborations, we can reach these populations using a grassroots approach. We can receive insights from these individual communities and try to engage community leaders as spokespersons for vaccine acceptance.

Healthcare providers have an advantage when communicating about the benefits of vaccines. A strong recommendation from a healthcare provider is the best predictor of adherence to the recommendation



for vaccination. The NJDOH has strong partnerships with professional organizations including the NJ chapters of the American Academy of Pediatrics, American Academy of Family Physicians, and the American College of Physicians. The Vaccine Preventable Disease Program (VPDP) supports providers by sharing evidence-based practices for communicating with patients who have concerns or hesitancy surrounding vaccination. The VPDP has also collaborated with these physician groups to deliver training webinars and conferences on how to utilize the principles of risk communication, health literacy, and active listening skills, and motivational interviewing to enhance provider-patient conversations surrounding vaccinations. In addition, the VPDP works with health services grantees including both statewide and municipality-based coalitions to promote the use of evidence-based practices to increase vaccination. These practices include using the statewide immunization registry to accurately assess patient vaccination needs, using standing orders to avoid missed opportunities for vaccination, and designating an office/practice immunization champion who could help to promote a culture of vaccination acceptance. Everyone from the front desk staff to the physician needs to be on-board with the pro-vaccination message to help foster a patient's choice for vaccination.

How will COVID-19 flu messaging be synced with existing flu vaccination efforts?

With the likelihood of both influenza viruses and the virus that causes COVID-19 circulating simultaneously this year, it will be of utmost importance that everyone 6 months of age and older get vaccinated against influenza. Although getting a flu vaccine will not protect against COVID-19, there are many benefits such as:

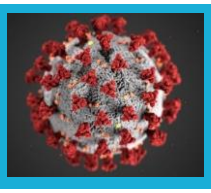
- Flu vaccines have been shown to reduce the risk of flu illness, hospitalization, and death.
- Getting a flu vaccine can also save health care resources for the care of patients with COVID-19.

The NJDOH is working with internal and external partners on a statewide flu vaccination communications campaign. One of these partners is the VPDP's health services grantee, the Partnership for Maternal and Child Health of Northern NJ (the Partnership). VPDP has provided funding to the Partnership to develop a flu communication campaign that is stressing the importance of the flu vaccine during the pandemic. NJDOH's campaign will reinforce and expand on the Partnership's campaign to reach the statewide population. Materials developed highlight vaccination benefits, correct misinformation, and inform the public about places to access vaccines.

In addition to a public awareness campaign and focus groups, what support structures will be required e.g., call centers?

The COVID-19 call centers will remain operational for the foreseeable future to provide information to the public by trained professionals. The NJ COVID-19 Information Hub will also remain an important online resource for the public as well as professionals to obtain information about various COVID-19 related information including the vaccine once it becomes available.

The Department is also working to implement strategies to ensure equitable distribution of safe and effective COVID-19 vaccines, when they become available. Strong public private partnerships are critical to ensuring that New Jersey is prepared to efficiently administer COVID-19 vaccine(s) to everyone who is



eligible to receive it. In this effort, the Department will rely on the existing strong working relationships with local public health agencies, healthcare providers, healthcare systems, and others.

To reduce any misinformation or concerns about the vaccine, it is important to ensure that New Jersey residents have accurate information readily available, such as the priority groups to be vaccinated and the decisions why these groups were chosen, importance of the vaccine to reduce the burden of the pandemic, safety and efficacy information, and other vital information sharing pieces of the vaccine.

D. Methods and Procedures for Local-Level Situational Awareness Monitoring

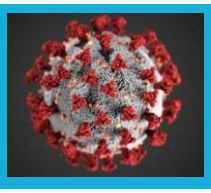
Supply-Side

Given New Jersey's plan for local delivery, the State will conduct regular check-in meetings with all local jurisdictions on at least a weekly basis to monitor human and physical resources dedicated to the implementation and execution of the State's vaccination plan.

The VTF will also utilize the "boots on the ground" resources, such as local and county health officers, local and county OEM coordinators, and NJ State Police regional representatives to continuously monitor site operations. These resources will conduct regular on-site check-ins and work with each POD site administrator and safety officer to ensure that any operational challenges are overcome and elevated when necessary through an established statewide Vaccine Command Center.

The Vaccine Command Center will be activated prior to the first delivery of vaccines to a distribution point and operate in close partnership with NJ State Police, county and State offices of emergency management, the National Guard, and the Office of Homeland Security and Preparedness. This center will provide a single conduit for the flow of bidirectional information and intelligence related to the transport, delivery, and deployment of vaccines throughout the State. The center will be physically located in the Regional Operations Intelligence Center (ROIC), which is the State's primary fusion center. Fusion centers serve as primary focal points within the state and local environment for the receipt, analysis, gathering, and sharing of threat-related information among federal, state, local, tribal, and territorial (SLTT) partners based on guidance provided by the U.S. Department of Homeland Security. Fusion centers are uniquely situated to empower front-line law enforcement, public safety, fire service, emergency response, public health, critical infrastructure protection and private sector security personnel to lawfully gather and share threat-related information, providing interdisciplinary expertise and situational awareness to inform decision-making at all levels of government.

The vaccine command center will be supported by reporting mechanisms. Metrics aligning with the reporting goals as detailed in Section 9F and including those listed in Section 15E will be reviewed daily or weekly. These metrics will inform the State of New Jersey about resource and technical assistance needs, emerging challenges, best practices, and opportunities for further quality improvement.



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The State of New Jersey also has an interest in local-level situational awareness to continually monitor user experience, barriers to access, and public opinion.

- Strategy: Engagement of and collaboration with community leaders, local stakeholders, and members from critical populations.
- Activities: Frequent communication on community challenges, perceptions, vaccine service challenges, such as lack of availability, other information to problem solve and further vaccination progress. This may be weekly for target populations, such as those in early Phases when significant public uncertainty or in latter Phases in communities where vaccine uptake has waned.
- Metrics: Weekly logs of communication that provide rich qualitative information used in quality improvement strategies.

E. COVID-19 Vaccination Program Metrics

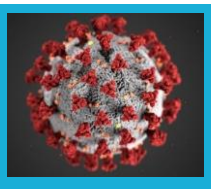
The metrics that will be posted on the state of New Jersey public-facing website are still being determined, but the following metrics are among those under consideration:

- Vaccine coverage
- Doses distributed to PODS
- Doses administered
- Adverse events. NJ will coordinate with federal partners evaluating VAERS and other reporting mechanisms to ensure consistency with federally reported adverse events.

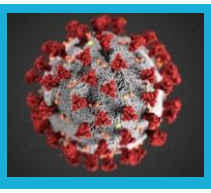
The following data sources to generate metrics are under consideration:

- NJIIS
- VTrckS
- VAERS
- Communicable Disease Reporting and Surveillance System (CDRSS)
- Site reports
- Engagement platform
- Public confidence sources
- On-site surveys
- Additional sources

The exact web location has not yet been determined. However, all other COVID-19 response-related data has been integrated into New Jersey COVID-19 Dashboard, which is accessible directly through the New Jersey COVID-19 Information Hub (https://covid19.nj.gov/) and through the New Jersey Department of Health's website (https://www.nj.gov/health/cd/topics/covid2019_dashboard.shtml). Metrics already available publicly in New Jersey include but are not limited to COVID-19 case data, mortality data, hospital census and discharge data, contact tracing data, and data specific to select congregate living settings (e.g. long-term care facilities).



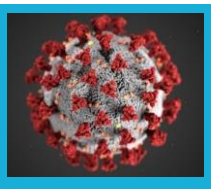
Appendix



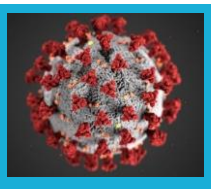
Section A: Synopsis of New Jersey's Regulatory Regime

A.1. Executive Orders during COVID-19 Pandemic (as of October 16, 2020)

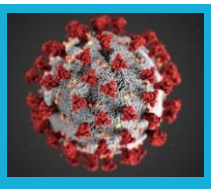
No.	Subject	Date Issued
102	Governor Murphy Signs Executive Order Establishing Coronavirus Task Force	2020/02/03
103	Governor Murphy declares a State of Emergency and a Public Health Emergency, effective immediately	2020/03/09
104	Governor Murphy Announces Aggressive Social Distancing Measures to Mitigate Further Spread of COVID-19 in New Jersey	2020/03/16
105	Governor Murphy Announces Changes to Upcoming New Jersey Elections in Response to COVID-19	2020/03/19
106	Governor Murphy Enacts Moratorium on Removals of Individuals Due to Evictions or Foreclosures	2020/03/19
107	Governor Murphy directs all residents to stay at home until further notice	2020/03/21
108	Governor Murphy invalidates any county or municipal restriction that in any way will or might conflict with any of the provisions of Executive Order No. 107	2020/03/21
109	Governor Murphy Suspends All Elective Surgeries, Invasive Procedures to Preserve Essential Equipment and Hospital Capacity	2020/03/23
110	Governor Murphy Signs Executive Order Requiring Child Care Centers Close on April 1 Unless Serving Children of Essential Workers	2020/03/25
111	Governor Murphy Signs Executive Order Directing Health Care Facilities to Report Data, Including PPE Inventory and Bed Capacity, On a Daily Basis	2020/03/28
112	Governor Murphy Signs Executive Order to Remove Barriers to Health Care Professionals Joining New Jersey's COVID-19 Response and Provide Protections for Front Line Health Care Responders	2020/04/01
113	Governor Murphy Signs Executive Order Authorizing Commandeering of Property Such as Medical Supplies	2020/04/02
114	Governor Murphy Directs U.S. and New Jersey Flags to Fly at Half-Staff Indefinitely in Honor of Those Who Have Lost Their Lives or Have Been Affected by COVID-19	2020/04/03
115	Governor Murphy Signs Executive Order to Strengthen COVID-19 Response Efforts by Allowing Certain Retirees to Return to Public Employment	2020/04/06
116	Governor Murphy Signs Executive Order Extending Statutory Deadlines for School Districts Whose Elections Were Moved from April to May	2020/04/07
117	Governor Murphy Signs Executive Order Waiving Student Assessment Requirements for 2019-2020 School Year	2020/04/07
118	Governor Murphy Signs Executive Order Closing State and County Parks to Further Social Distancing	2020/04/07
119	Governor Murphy Signs Executive Order Extending Public Health Emergency in New Jersey	2020/04/07
120	Governor Murphy Announces Postponement of June 2nd Primary Elections until July 7th	2020/04/08



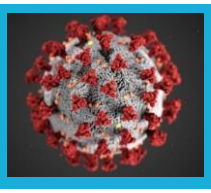
No.	Subject	Date Issued
121	Governor Murphy Signs Executive Order Allowing Greater Weight Limit for Vehicles Carrying COVID-19 Relief Supplies	2020/04/08
122	Governor Murphy Signs Executive Order to Cease All Non-Essential Construction Projects and Imposes Additional Mitigation Requirements on Essential Retail Businesses and Industries to Limit the Spread of COVID-19	2020/04/08
123	Governor Murphy Signs Executive Order Extending Insurance Premium Grace Periods	2020/04/09
124	Governor Murphy Signs Executive Order to Establish a Process to Grant Temporary Reprieve to Certain At-Risk Inmates	2020/04/10
125	Governor Murphy Signs Executive Order to Implement Additional Mitigation Requirements on NJ TRANSIT, Private Carriers, and Restaurants to Limit the Spread of COVID-19	2020/04/11
126	Governor Murphy Signs Executive Order Prohibiting Cable and Telecommunications Providers from Terminating Internet and Voice Service	2020/04/13
127	Governor Murphy Signs Executive Order Extending Certain Deadlines Associated with Rulemaking	2020/04/14
128	Governor Murphy Signs Executive Order Providing Critical Short-Term Support for Renters	2020/04/24
129	Governor Murphy today signed Executive Order No. 129, which extends Retired Officer Carry Permits by a period of 90 days until after the ongoing Public Health Emergency ends.	2020/04/27
130	Governor Murphy Signs Executive Order Allowing Municipalities to Extend Grace Period for May 1st Property Tax Payments until June 1st	2020/04/28
131	Governor Phil Murphy today signed an executive order creating a commission charged with advising the administration on the timing and preparation for New Jersey's recovery from the COVID-19 shutdown.	2020/04/28
132	Governor Murphy Signs Executive Order Allowing Electronic Petition Submission and Signature Collection for Initiatives and Referenda	2020/04/29
133	Governor Murphy Signs Executive Order Reopening State Parks and Golf Courses	2020/04/29
135	Governor Phil Murphy today signed Executive Order No. 135, suspending in-person requirements for receipt of a marriage license and marriage ceremonies, and for the receipt of working papers for minors.	2020/05/01
136	Governor Murphy Signs Executive Order Extending Statutory Deadlines for Various Environmental Laws	2020/05/02
137	Governor Murphy Signs Executive Order to Recognize New Fiscal Realities Due to COVID-19 Pandemic	2020/05/04
138	Governor Murphy Signs Executive Order Extending Public Health Emergency in New Jersey	2020/05/06
140	Governor Murphy Names Restart and Recovery Advisory Council	2020/05/08
141	Governor Murphy today signed Executive Order No. 141 mandating that all local, county, and regional health departments use the CommCare platform to support their contact tracing efforts.	2020/05/12
142	Governor Murphy Signs Executive Order Permitting Resumption of Non-Essential Construction, Curbside Pickup at Non-Essential Retail Businesses, and Gatherings in Cars	2020/05/13
143	Governor Murphy Signs Executive Order Allowing Beaches, Boardwalks, Lakes, and Lakeshores to Remain Open with Social Distancing Measures in Place	2020/05/14



No.	Subject	Date Issued
144	Governor Murphy Signs Executive Order to Protect Public Health by Mailing Every Registered Voter a VBM Ballot or Application Ahead of the Primary Election	2020/05/15
145	Governor Murphy Signs Executive Order Allowing Elective Surgeries and Invasive Procedures to Resume on May 26	2020/05/15
146	Governor Murphy Signs Executive Order to Reopen Charter Fishing and Watercraft Rental Businesses	2020/05/16
147	Governor Murphy Signs Executive Order	2020/05/18
148	Governor Murphy Signs Executive Order Increasing Capacity Limit on Outdoor Gatherings	2020/05/22
149	Governor Murphy Signs Executive Order Allowing Resumption of Child Care Services, Youth Day Camps, and Organized Sports Over the Coming Weeks	2020/05/30
150	Governor Murphy Announces Outdoor Dining Protocols and Process to Expand Premises for Liquor License Holders	2020/06/03
151	Governor Murphy Signs Executive Order Extending Public Health Emergency in New Jersey	2020/06/04
152	Governor Murphy Signs Executive Order Lifting Limits on Indoor and Outdoor Gatherings	2020/06/09
153	Governor Murphy Signs Executive Order Opening Pools Effective June 22, and Opening Additional Outdoor Recreational Businesses	2020/06/09
154	Governor Murphy Signs Executive Order Allowing Personal Care Service Facilities to Open Effective June 22	2020/06/13
155	Governor Murphy Signs Executive Order Allowing for Limited In-Person Instruction at Institutions of Higher Education and Trade and Training Schools Beginning July 1	2020/06/18
156	Governor Murphy Announces Increased Indoor and Outdoor Gathering Capacity Limits	2020/06/22
157	Governor Murphy Signs Executive Order Establishing Rules for Indoor Dining, Indoor Recreational Facilities, and Individualized Instruction at Gyms and Fitness Centers	2020/06/26
158	Governor Murphy Signs Executive Order Temporarily Pausing the Resumption of Indoor Dining	2020/06/29
159	Governor Murphy Signs Executive Order Extending Certain Statutory Deadlines Across State Government - Appendix To Executive Order No. 159	2020/06/30
160	Governor Murphy Directs U.S. and New Jersey Flags to Fly at Full Staff Starting July 3	2020/07/02
161	Governor Murphy Announces Increased Outdoor Gathering Capacity Limit	2020/07/02
162	Governor Murphy Signs Executive Order Extending Public Health Emergency in New Jersey	2020/07/02
163	Governor Murphy Signs Executive Order Requiring Individuals to Wear Masks in Outdoor Public Spaces When They Cannot Social Distance	2020/07/08
164	Governor Murphy Announces Postponement of Annual Municipal and County Party Committee Reorganization Meetings	2020/07/13
165	Governor Murphy Signs Executive Order Lifting 50 Percent Capacity Limits on NJ TRANSIT and Private-Carrier Vehicles	2020/07/13
166	Governor Murphy Signs Executive Order Creating Greater Oversight and Accountability for Federal COVID-19 Resources	2020/07/17
168	Governor Murphy Signs Executive Order Allowing the Resumption of Contact Practices and Competitions for Certain Organized Sports in Outdoor Settings	2020/07/20



No.	Subject	Date Issued
169	Governor Murphy Signs Executive Order which clarifies Executive Order No. 164 and states that the postponement of annual municipal and county party committee reorganization meetings is only applicable to municipal party committees and county party committees that held elections during the July primary elections.	2020/07/20
170	Governor Murphy Signs Executive Order Extending Certain Statutory Deadlines Across State Government Appendix To Executive Order No. 170	2020/07/31
171	The Order extends the Public Health Emergency that was declared on March 9, 2020 through Executive Order No. 103, which was previously extended on April 7, May 6, June 4, and July 2.	2020/08/01
172	Governor Murphy Signs Executive Order Allowing Public Employees to Immediately Enroll in State Health Benefits Program	2020/08/03
173	Governor Murphy Announces Decreased Indoor Gathering Capacity Limit	2020/08/03
175	Murphy Administration to Open New Jersey's Schools For In-Person Instruction Subject to Critical Health and Safety Protocols	2020/08/13
177	Governor Murphy Signs Executive Order to Protect Public Health by Mailing Every Active Registered Voter a VBM Ballot Ahead of the General Election	2020/08/14
178	Governor Murphy Signs Executive Order Extending Certain Statutory Deadlines Across State Government Appendix To Executive Order No. 178	2020/08/14
179	Governor Phil Murphy signed an executive order to make modifications to this year's primarily vote-by-mail (VBM) General Election.	2020/08/25
180	Governor Murphy Signs Executive Order Extending Public Health Emergency in New Jersey	2020/08/27
181	Governor Murphy Signs Executive Order Allowing Gyms and Indoor Amusement and Water Parks to Reopen Effective Tuesday, September 1	2020/08/27
183	Governor Murphy Signs Executive Order Allowing the Resumption of Indoor Dining Effective Friday, September 4	2020/09/01
186	Governor Murphy Signs Executive Order Extending Public Health Emergency in New Jersey	2020/09/25
187	Governor Murphy Signs Executive Order Allowing the Resumption of Contact Practices and Competitions for Certain Organized Sports in Indoor Settings	2020/10/12
189	Governor Murphy Signs Executive Order Extending 2019 Corporate Business Tax Calendar Year Return Filing Deadline	2020/10/15
190	Governor Murphy Signs Executive Order Extending Utility Shutoff Moratorium Through March 15, 2021	2020/10/15



A.2. Relevant NJDOH Regulatory Actions during COVID-19 Pandemic

COVID-19 Temporary Operational Waivers and Guidelines

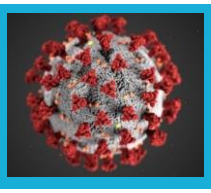
- Standing Orders
- Executive Directives
- Health Facilities
- EMS Waivers
- Temporary Public Health Rule Waivers
- Allocation of Scarce Resources

Standing Orders

- Standing Order for COVID-19 Testing
  - Frequently Asked Questions

Executive Directives

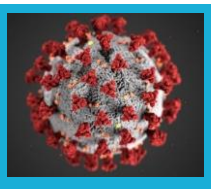
- ED 20-002: Authorization for Paramedics to Work in Hospital Setting (March 17, 2020)
- ED 20-003: Authorization for Members of the Healthcare Provider Community to Conduct COVID-19 Testing Through Swabbing (March 19, 2020)
- ED 20-004: Authorization for Long Term Care Facilities to Hire Out-of-State Certified Nurse Aides (March 27, 2020)
- ED 20-005: Authorization for Assisted Living Facilities, Assisted Living Programs and Comprehensive Personal Care Homes to Hire Out-of-State Certified Nurse Aides (March 31, 2020)
- ED 20-006: Implementation of Allocation Policies (April 11, 2020)
- ED 20-007: Authorization for New Jersey's Level I Trauma Centers to Coordinate Regional Efforts Related to COVID-19 Surge Planning & Expanding Hospital Bed Capacity (April 11, 2020)
- ED 20-008: Authorization for Health Care Facilities to Add Ventilator Beds (April 14, 2020)
- ED 20-009: One-Paramedic Death Pronouncement (April 16, 2020)
- ED 20-010: Disposition of Remains (April 22, 2020, revised August 20, 2020)
  - Communicable Disease Alert Form
- ED 20-011: Establishment of the Emergency Health Care Provider Registry (April 28, 2020)
- ED 20-012: Issuance of Standing Order for COVID-19 Testing (May 12, 2020)
- ED 20-013: LTC Staff Testing Requirements for COVID-19 (May 12, 2020, revised May 20, 2020)
  - Frequently Asked Questions (rev. May 28, 2020)
- ED 20-014: COVID-19 Protocols for Food or Beverage Establishments Offering Service in Outdoor Areas (June 3, 2020)
- ED 20-015 COVID-19 Protocols for Tanning Facilities and Body Art Establishments (June 13, 2020)
- ED 20-016 COVID-19 Protocols for Ambulatory Surgery Centers Resuming Elective Surgery and Invasive Diagnostic Procedures (rev. July 29, 2020)
- ED 20-017 Standards and Protocols for Visitors and Facility Staff (June 19, 2020; supersedes March 2016 visitation guidance memorandum)
- ED 20-018 COVID-19 Protocols for Hospitals Resuming Elective Surgery and Invasive Diagnostic Procedures (June 25, 2020)
- ED 20-019 COVID-19 Protocols for Food or Beverage Establishments Offering Service in Outdoor and Indoor Areas (June 26, 2020)
- ED 20-020 Support Persons in Labor and Delivery Settings (June 29, 2020)



- ED 20-021 Child Care and Youth Summer Camp Standards (June 30, 2020)
- ED 20-022 Standards for Pools and Aquatic Recreation Facilities (July 1, 2020)
- ED 20-023 Standards for Outdoor Amusement and Water Parks (July 1, 2020) superseded by ED 20-029, below
- ED 20-024 Protocols for Hotel Sanitization (July 9, 2020)
- ED 20-025 Protocols and Conditions for Visitation of Pediatric, Developmentally Disabled and Intellectually Disabled Residents of Long Term Care Facilities
- ED 20-026 Resumption of Services in all Long-Term Care Facilities (August 10, 2020)
- ED 20-027 Hospital Personal Protective Equipment Stockpiles (August 24, 2020)
- ED 20-028 Guidelines for Health Clubs, Gyms and Fitness Centers (August 27, 2020)
  — Guidance criteria
- ED 20-029 Health and Safety Standards for Outdoor and Indoor High-Touch Amusement and Recreation Activities (August 28, 2020, supersedes ED 20-023 above)
  — Guidance criteria
- ED 20-030 Health and Safety Standards for Indoor Dining (August 31, 2020)
  — Guidance criteria
- ED 20-032 Child Care Standards Pursuant to EO 149 (September 18, 2020)

Health Facilities

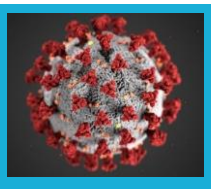
- 3-13-2020 For Licensed Inpatient Facilities
- 3-13-2020 For Ambulatory Care, Adult and Pediatric Care Facilities
- 3-13-2020 For Home Health Agencies and Hospice Facilities
- 3-13-2020 Mandatory Guidelines for Visitors and Facility Staff – Superseded
- 3-16-2020 Mandatory Guidelines for Visitors and Facility Staff – Mental Health/SUD Programs
- 3-16-2020 Mandatory Guidelines for Visitors and Facility Staff – Supersedes the 3-13-2020 Guidelines
- 3-26-2020 Waiver of Routine Third Party Inspections
- 3-26-2020 Extension of Certified Assisted Living Administrators Certification
- 3-26-2020 Extension of Certified Medication Aides Certification
- 3-26-2020 Extension of Certified Nurse Aide's Certification
- 3-26-2020 Extension of License Renewals During COVID-19 State of Emergency
- 3-26-2020 Waiver of Credentialing Standards – Acute Care Hospitals
- 3-28-2020 Temporary Waivers During COVID-19 State of Emergency – LTC
- 3-29-2020 One Support Person in Labor and Delivery Settings – Acute Care Hospitals Superseded by Executive Directive 20-020, above
- 3-31-2020 Waiver of Credentialing Standards and Renewal Deadlines - LTC
- 3-31-2020 Hospital Discharges and Admissions to Post-Acute Settings - Superseded by 4-13 Emergency Curtailment of Admissions
- Accepting Admissions Guidance: Accepting Patients During COVID-19 Pandemic Superseded
- 4-4-2020 Infection Prevention and Control of COVID-19 in Assisted Living Residences
- 4-4-2020 Notification of Residents, Families, Visitors and Staff in the Event of a Contagious Disease Outbreak
- 4-7-2020 Temporary Waivers During COVID-19 State of Emergency - Hospitals
- 4-13-2020 Emergency Curtailment of Admissions
- 4-14-2020 Temporary Waiver of Nurse Aide Certification Requirements



- 4-15-2020 Temporary Waiver of Examination Deadline for Certified Medication Aides
- 4-15-2020 Temporary Waiver of Nurse Aide Competency Requirements
- 4-17-2020 Waiver of APN/Anesthesia and Certified Registered Nurse Anesthetists (CRNA) requirements
- 4-17-2020 Telemedicine Permitted to Replace On-Site Visit by Health Care Practitioner
- 4-17-2020 Dialysis Staffing Waiver
- 4-23-2020 Recertification of Inactive Assisted Living Administrators Corrected 5-15-20
- 4-23-2020 Blanket Waiver for Home Hospice Programs
- 4-24-2020 Blanket Waiver for Home Health Agency Licensing Standards
- 4-25-2020 Support Persons for Patients with Disabilities Superseded by 5-12-20 waiver, below
- 4-29-2020 Temporary Waiver of Requirements for Nurse Aide Certification
- 5-8-2020 Temporary Waiver - Maintenance Requirements for Respiratory Care Equipment Corrected 5-28-20
- 5-8-2020 Temporary Waiver - Opioid Treatment At-Home Medication
- 5-12-2020 Support Persons for Patients with Disabilities
- 5-14-2020 Use of Remdesivir in Treatment of Patients with COVID-19 Superseded by 6-26-20 policy, below
- 5-19-2020 Guidance for Resumption of Elective Surgeries for Hospitals
- 5-19-2020 Guidance for Resumption of Elective Surgeries for Ambulatory Surgical Centers Superseded by ED 20-016, above
- 5-21-2020 Memo: Temporary Feeding Assistant Training
- 6-5-2020 Temporary Waiver: Licensing Requirements and Fees for Collection Stations
- 6-8-2020 Temporary Waiver: Certification of Nurse Aides in Long Term Care Facilities
- 6-26-2020 Remdesivir Distribution, Reporting and Use for Treatment of Patients with COVID-19
- 8-7-2020 Nurse Aide Certification Extension
- 8-7-2020 Criminal Background Clearances for Assisted Living Administrators

EMS Waivers

- ALS Certification Extension
- BLS Certification Extension
- BLS Crewmember Requirements
- MICU Crewmember Requirements
- Out of State BLS Provider
- Paramedic Certification Extension
- SCTU Crewmember Requirements
- Unlicensed Vehicle
- ALS Triage to Home
- BLS Triage to Home
- Expired EMT Re-Entry - COVID19
- Expired Paramedic Re-Entry - COVID19
- Recertification of Inactive Paramedics
- EMT Reciprocity
- MAV and BLS Ambulance Service PPE Requirements

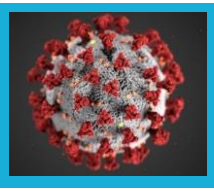


Temporary Public Health Rule Waivers

- Licensure of Persons for Public Health Positions (July 13, 2020)

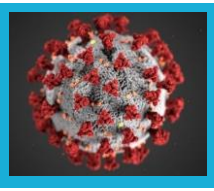
Allocation of Scarce Resources

- DOH Executive Directive
- Allocation Policy
- Attorney General Directive

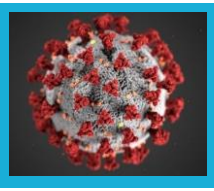


A.3. Relevant NJ Division of Consumer Affairs Regulatory Actions during COVID-19 Pandemic (as of October 2, 2020)

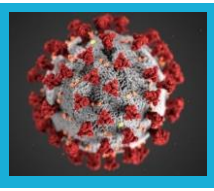
Healthcare Workforce Expansion - Temporary Licensure/Relaxation of Practice Restrictions				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**
3/19/2020	Accelerated Temporary Licensure Reciprocity Licensure	These rule waivers allow health care providers licensed in other states to obtain New Jersey temporary licensure and provide services to New Jersey patients either through telemedicine or in-person.	View Waivers	Waiver expiration concurrent with Executive Order #103. Licensure expiration 180 days after issuance unless otherwise stated by Division
3/20/2020	Telehealth	Temporary waiver of telemedicine rules to allow healthcare practitioners to more easily provide care via telemedicine.	DCA-W-2020-06	Concurrent with Executive Order #103
4/3/2020	Temporary retiree license re-activation	Permits temporary re-activation of healthcare licenses that lapsed within the last 5 years.	Executive Order #112 and DCA-AO-2020-02	Concurrent with Executive Order #103
4/3/2020	Temporary license for foreign-licensed physicians	Temporary medical license for those licensed, in good standing, in another country who have engaged in practice for at least five years and have engaged in clinical practice within the last five years.	Executive Order #112 and DCA-AO-20-02	Concurrent with Executive Order #103
4/3/2020	Advanced Practice Nurse (APN) Joint Protocol-Temporary Suspension	Temporary suspension of the requirement for an APN to enter a joint protocol with a collaborating physician.	Executive Order #112 and DCA-AO-2020-02	Concurrent with Executive Order #103



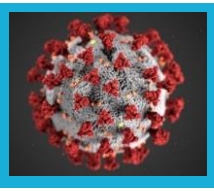
4/3/2020	Physician Assistant (PA) Physician Delegation Agreement-Temporary Suspension	Temporary suspension of the requirement for a PA to enter into a signed delegation agreement.	Executive Order #112 and	Concurrent with
			DCA-AO-2020-02	Executive Order #103
4/3/2020	Temporary waiver of NJ CDS Registration as precondition for registering with NJ PMP	Temporary suspension of the requirement to hold a controlled dangerous substance registration in order to register with the Prescription Monitoring Program for healthcare professionals who receive an expedited temporary license.	Executive Order #112 and	Concurrent with
			DCA-AO-2020-02	Executive Order #103
5/5/2020	Temporary Emergency Graduate License Program	Permits recent graduates of certain nursing, pharmacy, physician assistant and respiratory care schools to obtain an emergency graduate license.	DCA-AO-2020-05 and	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
5/13/2020	Pharmacist participation in COVID-19 testing	Permits pharmacists in New Jersey to collect specimens to test for COVID-19 or its antibodies using tests approved by the FDA or authorized pursuant to an Emergency Use Authorization, and requires pharmacists to notify the Board of Pharmacy, maintain records consistent with Board recordkeeping requirements, and comply with certain safety precautions for testing.	DCA-AO-2020-06 and	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
			DCA-W-2020-10	
5/18/2020	Healthcare Services in Office Practices	As of 5:00 a.m. on Tuesday, May 26, elective surgeries and elective invasive procedures may resume. This rule establishes standards for the safe provision of in-person, office-based health care and mitigating the spread of COVID-19.	**DCA-AO-2020-07**	Concurrent with the end of the state of emergency or the public health emergency, whichever is later.



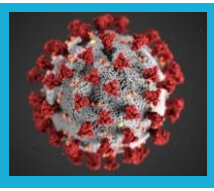
6/14/2020	Reopening of Personal Care Services: Cosmetology and Massage Bodywork Therapy Services	Personal care services by licensees of the New Jersey Board of Cosmetology and Hairstyling and the New Jersey Board of Massage and Bodywork Therapy may resume as of 6:00 a.m. on Monday, June 22, 2020, subject to the limitations and precautions set forth in the Administrative Order	DCA-AO-2020-09	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
6/18/2020	Veterinary Services	The New Jersey Division of Consumer Affairs has issued an Administrative Order which establishes practices and precautions for licensed veterinarians to protect patients, clients, veterinarians, and office staff from the continued risks posed by COVID-19.	DCA-AO-2020-10	Concurrent with the end of the state of emergency or the public health emergency declared pursuant to Executive Order #103 , whichever is later.
7/1/2020	Reopening of Personal Care Services: Cosmetology and Massage Bodywork Therapy Services	Amended Order controlling personal care services by licensees of the Board of Cosmetology and Hairstyling and the Board of Massage and Bodywork Therapy: Services may resume as of June 22, 2020, and services requiring removal of face coverings may resume July 2, 2020, subject to revised screening questions and other limitations and precautions set forth in this Order.	DCA-AO-2020-11	Concurrent with the end of the state of emergency or the public health emergency declared pursuant to Executive Order #103 , whichever is later.
7/13/2020			DCA-AO-2020-12 and	Concurrent with the end of the state of emergency or public health emergency



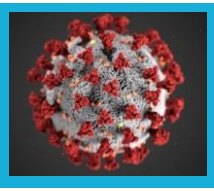
	Emergency Graduate Licensure Program for Mental Health Professionals	Permits recent graduates of certain social work and professional counselor schools to obtain an emergency graduate license.	DCA-W-2020-11	declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
7/15/2020	Temporary Certification of Alcohol and Drug Counselor Interns	Grants Alcohol and Drug Counselor Interns working in certain settings a CADC temporary certification, allowing them to perform telehealth and telemedicine.	DCA-AO-2020-13 and DCA-W-2020-12	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
7/29/2020	Waiver of On-Site Supervision for Audiologists and Speech-Language Pathologists Temporary Licensees, Occupational Therapy Assistants, and Physical Therapist Assistants	Waives on-site direct, face-to-face evaluations of audiologist and/or speech-language pathologist temporary licensees, on location face-to-face contact with and observation of occupational therapy assistants, and on-site supervision of physical therapist assistants. Supervision may instead be provided via electronic means.	DCA-AO-2020-14 and DCA-W-2020-13	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
8/11/2020	Authorization of Telemedicine Encounters	Administrative Order and waiver of rules to allow healthcare practitioners to utilize telemedicine encounters to meet CDS prescribing requirements.	DCA-AO-2020-15 and DCA-W-2020-14	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later; or the end of the telemedicine allowance designated by the U.S. Secretary of Health and Human Services on March 16, 2020; unless earlier terminated by the Director.
Prescription Drugs in Short Supply				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**
3/29/2020	Restrictions on Prescribing and Dispensing of certain drugs	Administrative Order imposing restrictions on prescribing and dispensing certain drugs including chloroquine and hydroxychloroquine.	DCA-AO-2020-01	Concurrent with Executive Order #103



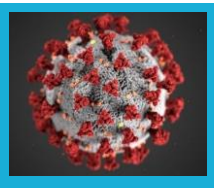
4/9/2020	Restrictions on Prescribing and Dispensing of certain drugs, includes additional exceptions	Administrative Order revising DCA-AO-20-01 (03/29/20) providing additional exceptions for prescribing certain drugs, including chloroquine and hydroxychloroquine, in post-acute care facilities, assisted living facilities, nursing homes and skilled nursing facilities.	DCA-AO-2020-03	Concurrent with Executive Order #103
Public Movers				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**
3/24/2020	Licensed Public Mover Inspection Waiver	Temporary waiver of rule to allow inspections that must performed when providing estimates to be conducted electronically rather than in person.	DCA-W-2020-01	Concurrent with Executive Order #103
Health Care Service Firms				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**
3/25/2020	In home plan-of-care evaluation by nurse supervisor	Temporary waiver of rule to allow plan-of-care evaluations by nursing supervisors to be completed electronically rather than in patients' homes.	DCA-W-2020-02	Concurrent with Executive Order #103
Office of Weights and Measures				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**
3/30/2020	OWM Fuel Standards Waiver	Temporary waiver of rule to allow industry to sell winter-blend fuel until May 1/20.	DCA-W-2020-03	1-May-20
5/1/2020	OWM Fuel Standards Waiver	Temporary waiver of rule to allow industry to sell winter-blend fuel.	DCA-W-2020-08	May 20, 2020, or the last day which the New Jersey DEP exercises enforcement discretion, whichever is later.



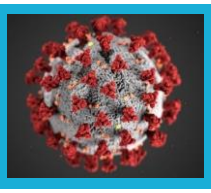
Professional & Occupational Boards				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**
4/3/2020	Electronic Signature for Funeral Services	Written signature requirements pertaining to prepaid funeral agreements and authorization to commence funeral services can be met by electronic signatures.	Executive Order #112 and DCA-AO-2020-02	Concurrent with Executive Order #103
4/13/2020	Temporary waiver of in-person continuing education coursework for 16 professional boards	Temporary waiver for 16 professional boards of rules requiring continuing education to be completed in person.	DCA-W-2020-04	Concurrent with Executive Order #103
4/30/2020	Temporary Modification of Mortuary Practitioner Requirement	Temporary modification permits interns registered with the State Board of Mortuary Science who are engaged in learning the practice of mortuary science under the supervision of a licensed practitioner to be present at the time of disposition in lieu of a licensed practitioner.	DCA-AO-2020-04 and DCA-W-2020-07	Concurrent with Executive Order #103
5/21/2020	Co-Prescribing of opioid antidote (naloxone)	Requires prescribing practitioners to co-prescribe an opioid antidote (naloxone) when continuously prescribing for chronic pain management under certain circumstances.	DCA-AO-2020-08	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
9/1/2020	Temporary Permits Issued by the Board of Cosmetology and Hairstyling	Temporary reinstatement and extension of the validity of temporary permits issued by the Board of Cosmetology and Hairstyling that expired on or after March 9, 2020, and extension of validity of temporary permits	DCA-AO-2020-16 and DCA-W-2020-15	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.



		set to expire on or after September 1, 2020, by one year after date of original expiration.		
9/1/2020	Health and Safety Standards for Nursing Programs, Certified Homemaker-Home Health Aide Training Programs, and Cosmetology Programs	Establishes standards for the reopening of registered professional nurse (RN) and licensed practice nurse (LPN) programs, certified homemaker-home health aide (CHHA) training programs, and cosmetology and hairstyling programs.	DCA-AO-2020-17	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
9/1/2020	Board of Pharmacy – Oral Authorization of Schedule II Medications	Pharmacists may now dispense up to a 30-day supply of Schedule II CDS upon the oral order of a prescriber. In addition, consistent with waivers issued by the United States Drug Enforcement Administration, follow up paper prescriptions may be submitted within 15 days, and may be submitted via facsimile. This waiver does NOT apply to "initial" opioid prescriptions for pain; it is only applicable for patients being treated for "chronic" pain.	DCA-W-2020-16	Concurrent with the end of the state of emergency or public health emergency declared in Executive Order #103, whichever is later, unless earlier terminated by the Director.
10/1/2020	Extensions of CPA Examination Credit Window and Continuing Professional Education Deadline	Temporary extension of exam credits to meet the18-month credit window for certain licensure applicants to take and pass the multi-part CPA examination; and for licensees, a 6-month extension for obtaining 120 CPE credits for the 2020 triennial licensure renewal.	DCA-W-2020-17	With regard to N.J.A.C. 13:29-1A.4, December 31, 2020. With regard to N.J.A.C. 13:29-6.2, June 30, 2021.
Bureau of Securities				
Effective Date	**Waiver Name**	**Description**	**Document**	**Expiration Date**



3/24/2020	Temporary Relief for Registrants Affected by the COVID-19 Outbreak	Temporary waiver of certain registration requirements for displaced financial professionals, waiver of requirements to obtain physical signatures on Form U4; and extension of certain filing requirements for State-Registered Investment Advisers.	BOS-EO-2020-01	Concurrent with Executive Order #103
4/30/2020	Extension Temporary Relief for Registrants Affected by the COVID-19 Outbreak	Temporary waiver of certain registration requirements for displaced financial professionals, waiver of requirements to obtain physical signatures on Form U4; and extension of certain filing requirements for State-Registered Investment Advisers.	BOS-EO-2020-02	Concurrent with Executive Order #103



A.4. New Jersey Emergency Health Powers Act: Statutory Authority for New Jersey Vaccine Education and Prioritization (N.J.S.A. 26:13-23)

23. (a) The commissioner shall develop and implement a New Jersey Vaccine Education and Prioritization Plan, as provided in subsection b. of this section, when the commissioner determines that: (1) an emergent condition exists and there is clear evidence that adverse and avoidable health outcomes from a preventable and acute communicable disease are expected to affect identifiable categories of high-risk individuals throughout the State; and (2) in order to protect or treat such individuals, assistance with the administration of vaccine is warranted due to a vaccine shortage.

(b) To protect the public health during a vaccine shortage, the commissioner shall issue an order to implement a New Jersey Vaccine Education and Prioritization Plan, which shall comprise:
   (1) procedures for the assessment of available vaccine Statewide;
   (2) procedures for the distribution and administration of vaccines that shall apply to physicians, nurses, health care facilities, pharmacies and others that dispense vaccines. The procedures shall include, but not be limited to, a definition of high-risk groups for priority protection or treatment in the event a vaccine shortage is imminent or existent; and
   (3) procedures for: (a) mobilizing public and private health resources to assist in vaccine distribution and administration; and

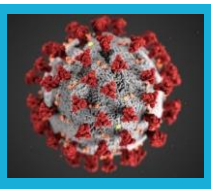
(b) reallocating available supplies of vaccine to most effectively meet the needs of the State's high-risk groups, if necessary.

(c) As used in this section, "vaccine" includes vaccines, immune products and chemoprophylactic and treatment medications.

(d) A person who willfully or knowingly violates the New Jersey Vaccine Education and Prioritization Plan or any procedures contained therein shall be liable for a civil penalty of $500 for each violation. The penalty shall be sued for and collected by the commissioner in a summary proceeding before the Superior Court pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

(e) The commissioner shall notify the appropriate professional or occupational licensing board or licensing authority, in the case of a facility, of repeated violations of the procedures by a health care professional or licensed facility.

L.2005,c.222,s.23.



A.5. Statewide Immunization Registry Act: Statutory Authority for the New Jersey Immunization Information System (N.J.S.A. 26:4-131 to N.J.S.A. 26:4-138)

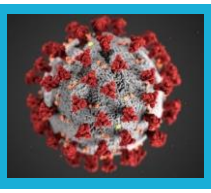
26 :4-131 Short title.

1. This act shall be known and may be cited as the "Statewide Immunization Registry Act."

26:4-132 Findings, declarations relative to Statewide automated and electronic immunization registry.

2. The Legislature finds and declares that the establishment of a Statewide automated and electronic immunization registry will serve the following public health purposes:
   a. ensure the greatest possible protection to the public from morbidity and death related to infectious diseases preventable by appropriate and timely immunizations;
   b. establish the public health infrastructure necessary:
      (1) to assist individuals and families to maximize their personal protection from vaccine-preventable diseases in as efficient and efficacious a manner as possible;
      (2) for community-wide and population-specific surveillance of potential susceptibility to outbreaks of vaccine-preventable diseases; and
      (3) for an effective response to a bio-terrorism event utilizing a potentially vaccine-preventable disease organism or to an epidemic or pandemic outbreak of a novel influenza virus of unusual virulence;
   c. ensure that a registrant, or the registrant's parent or legal guardian if the registrant is a minor, can more easily obtain from his health care provider or local health authority, or by other means as determined by the Commissioner of Health and Senior Services, the registrant's full immunization history if the registrant changes health care providers or requires documentation of immunization;
   d. provide health care providers, licensed child care centers, schools, colleges, and other public agencies and private organizations authorized to access the immunization registry with information concerning immunizations and other preventive health screenings, and the ability to determine relevant immunization and other preventive health screening histories of the individuals whom they serve;
   e. provide the State with greatly improved accuracy in its records concerning immunization rates among the State's residents;
   f. improve the State's ability to respond to outbreaks of communicable and vaccine-preventable diseases in a manner that reduces the risk of unnecessary additional immunizations;
   g. enable the efficient allocation of public health resources to provide the widest possible protection of the general population from vaccine-preventable diseases;
   h. ensure that all vulnerable children can be brought to completed immunization status as quickly as possible following manufacturing or distribution delays that may occur; and
   i. establish the legal and administrative framework necessary to ensure a properly functioning, universal, Statewide immunization registry inclusive of both public and private partners working cooperatively to share immunization data in a timely manner.

26:4-133 Definitions relative to Statewide automated and electronic immunization registry.



3. As used in this act:
   - "Commissioner" means the Commissioner of Health.
   - "Department" means the Department of Health.
   - "Health care provider" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) or a health care professional whose practice is regulated pursuant to Title 45 of the Revised Statutes.
   - "Registry" means the New Jersey Immunization Information System established pursuant to this act.

26:4-134 Statewide automated and electronic immunization registry.

4.a. There is established a Statewide automated and electronic immunization registry, to be designated as the New Jersey Immunization Information System, in the Department of Health. The registry shall be designed to serve as a single repository of immunization records to aid, coordinate, and help promote effective and cost-efficient disease screening, prevention, and control efforts in the State.

b. A newborn infant in New Jersey, who is born on or after January 1, 1998, shall be enrolled in the registry immediately following birth unless the parent or legal guardian of the infant provides a written request to not participate in the registry.
A child born prior to January 1, 1998 may be enrolled in the registry at the parent's or legal guardian's written request.

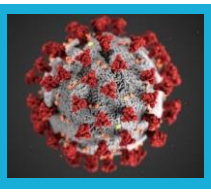
c. Access to the information in the registry shall be limited to: health care providers, schools, colleges, licensed child care centers, and public agencies, and private organizations as determined by regulation of the commissioner. A registrant, or the registrant's parent or legal guardian if the registrant is a minor, shall have access to the registrant's immunization and other preventive health screening information in the registry.

d. The information contained in the registry shall be used for the following purposes:
   (1) to help ensure that registrants receive all recommended immunizations in a timely manner by providing access to the registrants' immunization records;
   (2) to help improve immunization rates by providing notice to registrants of overdue or upcoming immunizations; and
   (3) to help control communicable diseases by assisting in the identification of persons who require immediate immunization in the event of a vaccine-preventable disease outbreak.

e. The authentic immunization and other preventive health screening record of a child, which shall consist of a paper or electronic copy of the registry entry that is a true and accurate representation of the information contained therein, obtained from the registry shall be accepted as a valid immunization and preventive health screening record of the registrant for the purpose of meeting immunization and preventive health screening documentation requirements for admission to a school, college, or licensed child care center.

f. A health care provider shall not discriminate in any way against a person solely because the person elects not to participate in the registry.

g. An authorized user granted access as provided in subsection c. of this section shall only access information in the registry on a specific patient or client who is presently receiving services, is under the user's care or is within the applicable governmental health authority's jurisdiction.



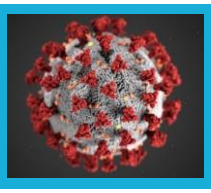
h. An agency, organization, or other entity authorized to access information in the registry shall not use any report made by a health care provider pursuant to this act in any punitive manner against the provider.

i. The commissioner, in consultation with the Public Health Council, shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act, including, but not limited to:
   (1) the establishment and maintenance of the registry;
   (2) the methods for submitting, and the content of, reports of immunizations to the registry, for which purpose the commissioner shall provide, to the maximum extent practicable, for reporting options to facilitate compliance with the requirements of subsection b. of this section;
   (3) procedures for the birth hospital of a newborn infant or health care provider, as applicable, to inform the parent or legal guardian of a newborn infant or minor of the purpose of the registry and its potential uses by parties having authorized access to registry information, and the content of that information;
   (4) procedures for a registrant, or the registrant's parent or legal guardian if the registrant is a minor, to review and correct information contained in the registry;
   (5) procedures for the parent or legal guardian of a newborn infant or minor, or a person over 18 years of age, to request to not participate in the registry at any time and to remove or inactivate information from the registry;
   (6) limits on, and methods of, access to the registry by those authorized pursuant to subsection c. of this section;
   (7) procedures for health insurers to obtain immunization information from the registry concerning only their covered persons, as well as summary statistics, which information or statistics shall not be used or disclosed for any other purpose than to:
      (a) improve patient care;
      (b) provide quality assurance to employers purchasing group coverage and to health care providers;
      (c) improve outreach and education efforts with respect to their covered persons and health care providers; and
      (d) monitor and improve quality of care standards as developed by professional organizations, accreditation agencies and government agencies in collaboration with the department; and
   (8) procedures for the department to disseminate statistical information and supporting commentary.

26:4-135 Immunity from liability.

5. Notwithstanding any other provision of this act to the contrary, a person or entity, who is authorized by the commissioner to report, receive or disclose information relating to the registry pursuant to this act, shall be immune from liability for:

a. reporting information to, receiving information from, or disclosing information received from, the registry in accordance with the provisions of this act or any regulation adopted pursuant thereto; and



b. any error or inaccuracy in the information that is reported to, received from, or disclosed after receipt from, the registry in accordance with the provisions of this act or any regulation adopted pursuant thereto, and any consequence of that error or inaccuracy.

26:4-136 Construction of act relative to obligations, rights of persons.

6. The provisions of this act shall not be construed to affect the obligation of any person, or the person's parent or legal guardian if the person is a minor, to comply with any immunization requirement, or the right of that person, parent or legal guardian to request an exemption from the immunization requirement on the grounds that an immunization is medically contraindicated or that the requirement conflicts with the religious tenets or practices of the person, parent or legal guardian, as otherwise established by statute or by regulation of the department.

26:4-137 Confidentiality of registry information.

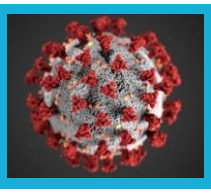
7. a. Information contained in the registry is confidential and shall be disclosed only for the purposes authorized by this act.

b. A person who is aggrieved as a result of a violation of this act may commence a civil action against the person or entity committing the violation to obtain appropriate relief, including actual damages, equitable relief and reasonable attorney's fees and court costs. Punitive damages may be awarded when the violation evidences wantonly reckless or intentionally malicious conduct by the person or entity who committed the violation.

c. A person who discloses information in violation of this act is guilty of a disorderly persons offense. Each disclosure made in violation of this act is a separate and actionable offense.

26:4-138 Certain transmissions of information permitted.

8. The provisions of this act shall not prohibit the transmission or exchange of immunization information from other government database systems, immunization registries of other states or similar regional registries officially recognized by those states, health maintenance organizations or health benefits plans, health insurance companies, practice management or billing vendors, or other similar databases containing immunization histories, if the transmission is in accordance with the provisions of this act and other relevant State and federal laws and regulations.



Section B: Memberships of Key COVID-19-specific Advisory Entities

B.1.a. NJDOH COVID-19 Professional Advisory Committee: Charter

Formed March 2020
Expanded September 2020

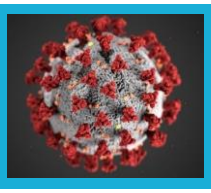
CHARTER
COVID-19 PROFESSIONAL ADVISORY COMMITTEE
NEW JERSEY DEPARTMENT OF HEALTH

On February 3rd, Governor Murphy issued Executive Order 102 convening the Coronavirus Task Force, to ensure a "whole of Government response" to this pandemic. Throughout the crisis, state leadership has engaged subject matter experts and thought leaders to guide New Jersey through this extraordinary and challenging time. The New Jersey Department of Health Professional Advisory Committee (PAC) was convened as one such forum to inform the Commissioner of Health. The Professional Advisory Committee (PAC) provides guidance to the Department to ensure that New Jersey's response to COVID-19 is based on the latest scientific, medical, ethical and public health evidence. The COVID-19 pandemic has resulted in significant health inequities in vulnerable communities. Health inequities are disparities in health or health care that are systemic and avoidable and, therefore, unfair or unjust. Health equity is a fundamental to the PAC's recommendations in the interest of preventing health inequity.

As the scale and impact of the COVID-19 crisis has evolved, the functions and focus areas of the PAC have evolved as well. The Committee previously informed allocation of critical care resources, distribution of scarce treatment pharmaceuticals (i.e. remdesivir), and targeted population-specific testing strategies (i.e. urban communities) during this public health emergency. Commencing in September 2020, the PAC will focus on comprehensive and equitable planning and rollout of COVID-19 vaccination in New Jersey. The novel SARS CoV-2 virus is the cause of an unprecedented COVID-19 epidemic and requires a response that applies an equity lens to the development of strategies and tactics. Elevating the health equity lens in all parts of the response is critical. The PAC's work complements and enhances ongoing and sustained health equity initiatives and prioritization within state agencies. A health equity lens is of even greater imperative given the predicted and realized implications and complications of this unique public health crisis for vulnerable populations. Further, as a result of the catastrophic nature of this public health crisis, the demographic of those who identify as at-risk, under-resourced, and underserved has widened to include those who traditionally never identified in these vulnerable ways.

The Professional Advisory Committee informs the health response to COVID-19 in the following ways:

- *Resource Allocation* – How resources and services are procured, promoted, and provided in proximity to those who most need or require them to survive or thrive.



- *Advisory and Consultative* – Active communication to and from community and constituency perspectives to inform considered ethical and equitable planning, policy, and practice and to build public confidence.
- *Proactive and Participatory* – Deliberative ideation and derivation of novel solutions. Community involvement endeavors to inspire public confidence and sense of ownership in the generation, implementation, and evaluation of public health interventions.
- *Access* – A holistic assessment of whether affordability, availability, accessibility, accommodation, and acceptability are attained and advanced.
- *Quality* – A consideration of the safety, effectiveness, patient-centeredness, timeliness, efficiency, and equitability of proposed initiatives.
- *Outcomes* – A descriptive, data-informed, and transparent synthesis of which population(s) or who survives versus thrives, who is adversely impacted or resilient, who is affected by collateral or generational damage, and/or who is at-risk for a continuum of outcomes.
- *Problem-Solving* – An evaluation of which solutions transform the status quo by averting systemic and structural inequities and bias.

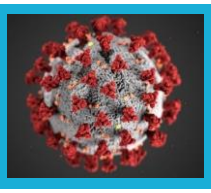
Committee expertise will be leveraged to enhance development, reach, and utility of overall and population-specific COVID-19 vaccination plans, policies, data-to-action, communications, and delivery activities.

As New Jersey progresses through the rollout of COVID-19 vaccine(s), the PAC may inform New Jersey's answers to such questions as:

- Have equity considerations been implemented at each stage of planning and delivery?
- Can the public have confidence that the available vaccine(s) is safe and effective?
- How will vaccine(s) be prioritized, or sub-prioritized given scarcity and operational constraints?
- How to ensure vaccine uptake is sufficient to facilitate as possible a return to pre-pandemic conditions?

To meet these varied purposes, specialized subcommittees of subject matter experts are convened as needed.

- On an ongoing basis, the NJDOH COVID-19 PAC's *Health Equity Subcommittee* monitors that New Jersey's COVID-19 vaccination initiative applies an equity lens in planning and a disparities focus in vaccine delivery. In the interest of mainstreaming equity, this subcommittee will routinely sit with the PAC.
- Meanwhile, the *Community Advocacy Subcommittee* is called as necessary to elevate community voices in order to better understand and inform public expectations of COVID-19 vaccine(s) risks, benefits, and availability. This will include representation from constituencies with historical vaccination trauma.
- Likewise, the *Medical Ethics and Systems Subcommittee* is convened as necessary to review scientific literature and medical guidance and to consider resource allocation within facilities. This body may also be called upon to provide advice on issues relevant to the Department of Health's health systems regulatory authority.



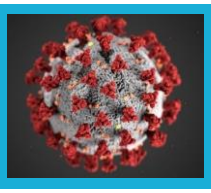
The PAC and its subcommittees will build and supplement ongoing vaccines-related engagement by the New Jersey Department of Health to raise awareness, provide education, and activate partnerships in New Jersey's communities.

The membership shall include New Jersey-specific expertise representing geographic and professional diversity. The current membership includes state officials, epidemiology and immunization experts, health systems and health practitioners, local health champions, infectious and chronic disease providers, ethics and legal experts, equity and inclusion leaders, academics, and health quality advisors drawn from across New Jersey. Membership is informed by recommendations of the Centers for Disease Control and Prevention and the Working Group on Readying Populations for COVID-19 Vaccine.

B.1.b. NJDOH COVID-19 Professional Advisory Committee: Membership

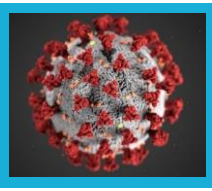
28 non-NJDOH members plus three current NJDOH personnel
^ = Also Health Equity Subcommittee member

- Judith M. Persichilli^, RN, BSN, MA, Commissioner, New Jersey Department of Health
- David Adinaro^, MD, M.Eng., FACEP, Deputy Commissioner, New Jersey Department of Health
- Eddy Bresnitz^, MD, MSCE, FACP NJ DOH Medical Advisor and Professional Advisory Committee Chair; former NJDOH Deputy Commissioner and State Epidemiologist; Adjunct Professor of Epidemiology, Rutgers University School of Public Health
- Kemi Alli, MD, Chief Executive Officer, Henry J. Austin Health Center
- Hon. Paul W. Armstrong^, J.S.C. (Ret.), MA, JD, LLM, Senior Policy Fellow and Judge in Residence, Program in Health Administration, Edward J. Bloustein School of Planning and Public Policy, Rutgers University and former Chairman of the New Jersey Bioethics Commission and the Governor's Council on AIDS.
- Megan Avallone, RN, MS, Director, Westfield Regional Health Department; President, New Jersey Association of County and City Health Officials
- Charletta A. Ayers^, MD, MPH, Associate Professor, Vice Chair, Department of Obstetrics, Gynecology & Reproductive Sciences, Rutgers Robert Wood Johnson Medical School
- Elisa V. Bandera^, MD, PhD, Professor and Chief, Cancer Epidemiology and Health Outcomes; Co-Leader, Cancer Prevention and Control, Rutgers University Cancer Institute of New Jersey; Professor of Medicine, Robert Wood Johnson Medical School
- Cathleen Bennett, JD, MA, President and Chief Executive Officer, New Jersey Hospital Association; former NJDOH Commissioner
- Damali Campbell-Oparaji^, MD, Assistant Professor of Obstetrics, Gynecology and Women's Health, Division of General Obstetrics and Gynecology, Rutgers University New Jersey Medical School; President, New Jersey Medical Association
- Lawrence Downs, JD, Chief Executive Officer, Medical Society of New Jersey
- Nir Eyal, DPhil, Henry Rutgers Professor of Bioethics and Director of the Center for Population–Level Bioethics (CPLB), Rutgers School of Public Health
- Margaret C. Fisher, MD, Infectious Disease Specialist, RWJBarnabas Health and Chair, Department of Pediatrics and Medical Director, The Unterberg Children's Hospital at Monmouth Medical Center,



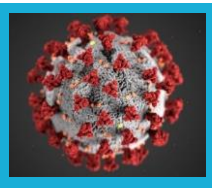
RWJBarnabas Health; Clinical Professor of Pediatrics, Rutgers University Robert Wood Johnson Medical School

- Robert C. Garrett, MHA, FACHE, Chief Executive Officer, Hackensack Meridian Health
- Brian Gragnolati, MBA, President and CEO at Atlantic Health System - Immediate Past Chair, American Hospital Association
- Fred M. Jacobs^, MD, JD, Executive Vice President, St. George's University, former Executive Vice President for Medical Affairs, Saint Barnabas Health Care System, former Commissioner, NJ Dept. Of Health and Senior Services
- David S. Kountz, MD, MBA, FACP, Founding Associate Dean, Diversity and Equity, Hackensack Meridian School of Medicine at Seton Hall University; Co-chief academic officer and Vice President, Academic Diversity, Hackensack Meridian Health; Vice President, Academic Affairs, Hackensack Meridian Health Jersey Shore University Medical Center
- Marc J. Levine, MD, President of Medical Society of New Jersey; President of Eastern Orthopaedic Association; Clinical Assistant Professor, Rutgers New Jersey Medical School; and Director Spine Surgery Program Robert Wood Johnson University Hospital/Hamilton
- Julie Morita, MD, Executive Vice President, Robert Wood Johnson Foundation; former Commissioner, Chicago Department of Public Health
- Mary E. O'Dowd, MPH, Executive Director of Health Systems and Population, Rutgers Biomedical Health Sciences, Rutgers, The State University of New Jersey; former NJDOH Commissioner
- Barry H. Ostrowsky, JD, President and Chief Executive Officer, RWJBarnabas Health
- Cynthia Y. Paige^, MD, MBA, Family Physician, Summit Medical Group
- Annette Reboli, MD, Professor of Medicine and Dean, Cooper Medical School of Rowan University
- Denise V. Rodgers, MD, FAAFP, Vice Chancellor of Interprofessional Programs, Rutgers Biomedical and Health Sciences (RBHS); Steering Committee Chair, Believe in Healthy Newark Culture of Health Initiative; Board Member, Greater Newark Healthcare Coalition; Professor, Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School
- Judith E. Schmidt, MSN, DHA (c), RN, Chief Executive Office New Jersey State Nurses Association
- Linda Schwimmer, JD, President and CEO, New Jersey Health Care Quality Institute; Co-founder, Mayors Wellness Campaign
- Marc M. Seelagy, MD, Pulmonologist, Allergy & Pulmonary Associates, P.A.; Medical Director of Critical Care Medicine, St. Francis Medical Center; and Medical Director of the Sleep Disorders Program, St. Francis Medical Center
- Michael E. Shapiro^, MD, FACS, Associate Professor of Surgery, Rutgers University, New Jersey Medical School; Chair, Bioethics Committee, University Hospital
- Kevin J. Slavin, MHA, President and Chief Executive Officer, St. Joseph's Health; Chair of the Board of Trustees, New Jersey Hospital Association
- Karma Warren^, MD, FAAEM, Assistant Professor of Emergency Medicine, Rutgers University, New Jersey Medical School; Chair, Community Engagement, Board Member, New Jersey Medical Association
- Patricia N. Whitley-Williams^, MD, Professor of Pediatrics, Chief, Division of Allergy, Immunology and Infectious Disease, Department of Pediatrics, Associate Dean for Inclusion and Diversity, Rutgers University Robert Wood Johnson Medical School



B.2.b. Governor's Restart and Recovery Commission: Overall structure

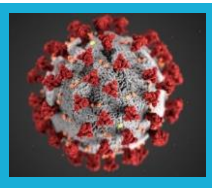
NJ Commission (Co-chairs: Kenneth Frazier & Dr. Shirley M. Tilghman)			
	Public & Social Services	**Economic / Fiscal**	**Health**
Working group chair(s)	• Administrator Lisa Jackson	• Richard Trumka • Tony Coscia	• Dr. Richard Besser
Commission	• Evelyn Colbert, Kenneth Frazier • Dr. Jonathan Holloway • Commissioner Carole Johnson (ex officio) • Secretary Jeh Johnson • Lt. Gov. Sheila Oliver (ex officio) • Reverend Dr. Regena Thomas	• Dr. Ben Bernanke • Jessica Gonzalez • State Treasurer Elizabeth Maher Muoio (ex officio) • Dr. Bill Rodgers	• Charles Lowrey • Denise Morrison • Commissioner Judith Persichilli (ex officio) • Neera Tanden • Dr. Shirley M. Tilghman
Government	• Jonathan Chebra • Joseph Kelley • Phillip Loureiro • Candice Alfonso	• Justin Braz • Joseph Kelley • Phillip Loureiro • Jeffrey Oakman • Dennis Zeveloff	• Candice Alfonso • Andrea Martinez-Mejia • Joseph Kelley • Phillip Loureiro • Shabnam Salih
Other	• N/A	• Rutgers: Dr. Carl Van Horn • NJEDA: CEO Tim Sullivan, Brian Sabina, Jorge Santos	• N/A
Note: More information can be found here: https://nj.gov/governor/admin/restartcommission.shtml			



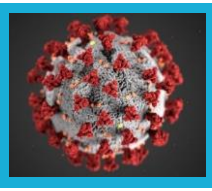
B.2.c. Governor's Restart and Recovery Commission: Membership by Sector

Facilities and Construction

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Marlene	Asselta	Southern New Jersey Development Council
David	Barry	Ironstate Development
Joe	Baumann	McManimon, Scotland, & Baumann
Staci	Berger	Housing and Community Development
Wassem	Boraie	Boraie Development LLC
David	Brogan	NJ Apartment Association
Sarah	Clarke	New Brunswick Development Corporation (DEVCO)
Tom	Considine	McKelroy and Deutch
Bill	Colgan	Community Healthcare Associates
Jeff	Crum	Community Asset Preservation Corporation
Morris	Davis	Rutgers Center for Real Estate
Eileen	Della Volle	KS Engineers
Mike	Demarco	Mack Cali Realty Corp
Joe	DeMark	Sheetmetal Workers
Janice	Fine	School of Management and Labor Relations
Jeremy	Farrell	LeFrak Organization



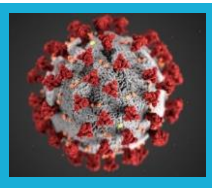
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Stephen	Fluhr	Unibail Rodamco Westfield
Christiana	Foglio	Community Investment Strategies Inc.
Carl	Goldberg	Canoe Brook Management LLC
Lori	Grifa	Archer Greiner
Derrek	Griggs	Affordable Housing Alliance
Michael	Hanrahan	American Institute of Architects NJ
Joe	Jingoli	Joseph Jingoli & Son Inc.
Lisa	John-Basta	Chiesa Shahinian & Giantomasi Law
Vincent	Lane	IUPAT DC 711
Michael	Maloney	UA Local 9
Nevins	McCann	Connell Foley
Mike	McGuinness	NAIOP
Gil	Medina	Coldwell Banker Richard Ellis
Bill	Mullen	New Jersey State Building & Construction Trades Council
Wendy	Neu	Hugo Neu
Darwin	Roman	National Association of Latino Professional Realtors South Jersey
John	Saraceno	Onyx
Carol Ann	Short	New Jersey Builders Association
David	Simon	Simon Property Group



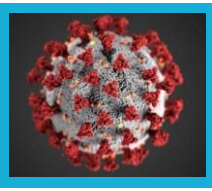
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Ron	Simoncini	Axiom Communications
William	Sproule	Atlantic States Regional Council of Carpenters
Elizabeth	Tice	K. Hovnanian Homes
Richard	Tolson	Bricklayers and Allied Craftworkers
Jerry	Zaro	Sills Cummis

Government

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Peggy	Anastos	Latinas United for Political Empowerment Fund (LUPE)
Ras	Baraka	Urban Mayors Association
Joe	Calabro	International Brotherhood of Electrical Workers, International Executive Council
Eugene	Caldwell	New Jersey County Jail Wardens Association
Mike	Cerra	League of Municipalities
Pat	Colligan	NJ State Policemen's Benevolent Association
Tom	DeGise	Hudson County Executive
Joe	DiVincenzo	Essex County Executive
John	Donnadio	New Jersey Association of Counties



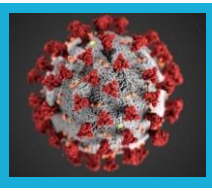
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Ed	Donnelly	New Jersey Firefighters Mutual Benevolent Association
Bob	Fox	New Jersey Fraternal Order of Police
Brian	Hughes	Mercer County Executive
Al	Kelly	Urban Mayor Association
Janice	Kovach	Mayor New Jersey League of Municipalities
Colleen	Lapp	Tax Collectors & Treasurers Association of NJ
Dennis	Levinson	Atlantic County Executive
Mike	Mastronardy	Sheriffs - Constitutional Officers Association
Steve	McConlogue	Professional Firefighters of New Jersey
John	McCormac	Mayor of Woodbridge Township
Dave	Miller	Mercer County Finance Officers
Janice	Mironov	NJ Conference of Mayors/New Jersey League of Municipalities
Frank	Moran	Urban Mayors Association
Teri	O'Connor	NJ Association of County Administrators
Steve	Peter	Clerks Constitutional Officers Association
Hetty	Rosenstein	Communications Workers of America
Gerry	Seneski	Cumberland County Finance Officer
Connor	Shaw	International Union of Journeymen and Allied Trades
Susan	Shin Angulo	Mayor of Cherry Hill



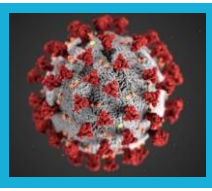
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Amol	Sinha	American Civil Liberties Union
Jim	Tedesco	Bergen County Executive
Steve	Tully	American Federation of State, County and Municipal Employees New Jersey
Jaclyn	Veasey	Mayor of Evesham Township
Matt	Watkins	Bloomfield Township Municipal Manager

Health Care

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Dr. Kemi	Alli	NJPCA and Henry J. Austin FQHC in Trenton
Bill	Anastassatos	Hospital-based Outpatient Services for Kessler Institution for Rehabilition
David	Baiada	Bayada Home Health Care
Cathy	Bennett	New Jersey Hospital Association (NJHA)
Mike	Beson	Guide Strategies
Maura	Collinsgru	NJ Citizen Action
Kevin	Conlin	Horizon Blue Cross Blue Shield
Joan	Dublin	NJPCA and Metropolitan FQHC in Jersey City
Shereef	Elnahal	University Hospital



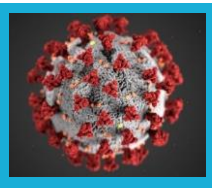
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Nancy	Fitterer	NJ Home Healthcare Hospice Association
Dr. Dovid	Friedman	Center for Health Education Medicine & Dentistry
Brian	Gragnolati	Atlantic Health System
Robert	Garrett	Hackensack Meridian Health
Perry	Halkitis	Rutgers School of Public Health
Heather	Howard	Princeton University - Robert Wood Johnson Foundation
Dr. Steve	Landers	CEO of Visiting Nurse Association
Dr. Marc J.	Levine	MSNJ
Ev	Liebman	AARP
Al	Maghazehe	Capital Health
Joe	Masciondaro	CarePlus
Ana	Montero	Red Cross Recovery
Kevin	O'Dowd	Cooper Hospital
Barry	Ostrowsky	RWJ Barnabas Health
Dr. Jubril	Oyeyemi	Cherry Hill Free Clinic & Virtua Health
Dr. Jon	Regis	Reliance Medical Group LLC
Jeff	Shanton	NJ Association of Ambulatory Surgery Centers
Milly	Silva	Service Employees International Union 1199
Kevin J.	Slavin	St. Joseph's Health



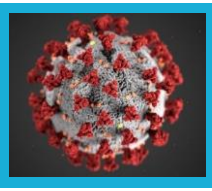
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Mark	Taylor	NJ Pharmacist Association
Keeanga	Taylor	Princeton University
Ward	Sanders	Health Plans Association
Dr. Mitchell	Weiner	NJ Dental Association
Debbie	White	Health Professionals and Allied Employees (HPAE)

Main Street

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Stephen	Blazejewski	New Jersey LGBT Chamber of Commerce
Linda	Bowden	PNC Bank-Small Business
Francisco	Cortes	New Jersey State Veterans Chamber of Commerce
Jeanne	Cretella	New Jersey Restaurant and Hospitality Association
Luis	Delahoz	Hispanic Chamber of Commerce
Leon	Fraser	New Jersey Small Business Development Center
Barri	Gibson	Ruby Red Roots
Bill	Granfield	SEIU Local 100 – Unite Here (restaurant workers)
John	Harmon	African American Chamber of Commerce NJ



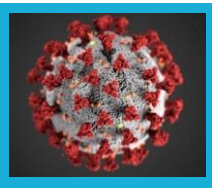
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Paul	Hoffmann	Liberty Science Center
Duvi	Honig	Orthodox Jewish Chamber of Commerce
Frank	Isoldi	Caldwell Banker
Jill	Johnson	Institution for Entrepreneurial Leadership
Peter	Kasabach	New Jersey Future
Raymond	Lamboy	Latin American Economic Development Association, Inc.
Richard	Lawton	NJ Sustainable Business Council
Brandon	McKoy	New Jersey Policy Perspective
Vonda	McPherson	Restaurant Operater Newark
John	McWeeney	New Jersey Bankers Association
Carmen	Mendiola	Restaurant and Small Business Advisory committee in Jersey City
Maria	Nieves	Hudson County Chamber of Commerce
Priti	Pandya-Patel	NJ Asian Indian Chamber of Commerce
Vipul	Patel	Asian American Retail Association
Ben	Pearlman	New Jersey Retail Merchants Association
Jill	Peterson	ABCO Federal Credit Union
Corinne	Power	Camden-Restaurant Operater
Christina	Renna	Chamber of Commerce, Southern New Jersey
Nadeem "Nick"	Saleem	Islamic Center of South Jersey/ United Wealth Group LLC



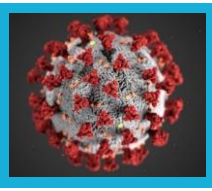
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
John	Sarno	Employers Association of NJ
Michele	Siekerka	New Jersey Business & Industry Association
Dean	Smith	NJ Main Street Alliance

Manufacturing and Supply Chain

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Jeff	Altschuler	Allied Beverage Group
Gabriel	Arreaga	Mondelēz International
Tiffany	Bohlin	FullBlue360
Laurel	Brennan	American Federation of Labor-Congress of Industrial Organizations
Patricia	Campos Medina, PHD	The Worker Institute, ILR Cornell University
Kim	Case	Research & Development Council (R&D)
Gail	Ciccione	Becton Dickinson
Adam	Ciongoli	Campbell Soup Company
Jessica	Culley	El Comite de Apoyo a Los Trabajadores Agricoles (CATA)
Sara	Cullinane	Make the Road
Linda	Doherty	New Jersey Food Council



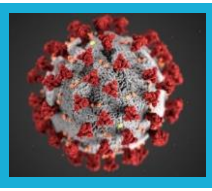
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Lisa	Dreilinger	Reckitt Benckiser (RB)
Adam	Glauberg	Johnson & Johnson
Dennis	Hart	Chemistry Council of New Jersey
Debbie	Hart	BioNJ
Dr. John	Impellizzeri	Rutgers University
Dr. Jean-Pierre	Issa	Coriell Institute for Medical Research
John	Kennedy	New Jersey Manufacturing Extension Program (NJMEP)
Shirley	Kline	Agriculture Community
Roxanne	Lagano	Zoetis Inc
Wendy	Lazarus	Pfizer
Samuel	Nesbit	FedEx
Dean	Paranicas	Healthcare Institute of New Jersey (HINJ)
Mark	Patterson	Badische Anilin und Soda Fabrik (BASF)
Alphonse	Rispoli	Teamsters
Charles	Rosen	Ironbound Farms
Nancy	Rurkowski	Bristol-Myer Squibb
Anthony	Russo	Commerce and Industry Association of New Jersey(CIANJ
Joe	Sheridan	Wakefern Food Corporation
Tom	Szaky	TerraCycle



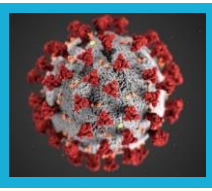
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Kim	Van Utrecht	United Parcel Service (UPS)
David	Young	United Food & Commercial Workers (UFCW)

Professional Services

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Neil	Bhaskar	Bode Foundation
Thomas	Bracken	NJ Chamber of Commerce
Charlene	Brown	American Telephone & Telegraph (ATT)
Kevin	Brown	Service Employees International Union 32-BJ
Cathleen	Callahan	Bank of America
Arthur	Cifelli	The Venn Group
Kevin	Cummings	Investors Bank
Marilyn	Davis	Altice - New Jersey Cable Telecommunications Association
Alma	DeMetropolis	JPMorgan Chase
Marcus	Dyer	WithumSmith + Brown
Mitch	Livingston	New Jersey Manufacturers
Laura	Matos	Kivvit, Latinas United for Political Empowerment PAC (LUPE)

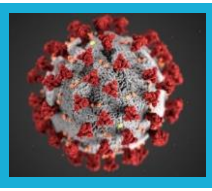


NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Carlos	Medina	Hispanic Chamber of Commerce
Michelle	Meyer-Shipp	Klynveld Peat Marwick Goerdeler (KPMG)
Pamela	Miller	Global Strategies
Christine	O'Brien	Insurance Council of NJ
Evelyn	Padin	New Jersey State Bar Association (NJSBA)
Raj	Parikh	Genova Burns
Braxton	Plummer	Verizon
Aaron	Price	New Jersey Tech Council
Brenda	Ross-Dulan	Princeton Chamber of Commerce
Jatinder	Singh	Account Vision LLC
Jackie	Taylor	Ernest & Young Global Limited (EY)
Gina	Tedesco	Golden Seeds
Ian	Trombley	NBC Universal
Kelly	Watson	Markel Consultants

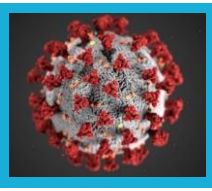


Social Services and Faith

NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Mohsen	Badran	ACCSES New Jersey Inc.
Tom	Baffuto	The ARC of NJ
Jessica	Berrocal	NJ Sisterhood
Jacob	Caplan	EasterSeals NJ
Tiffany	Cardwell	Coalition of Day Care Centers in Jersey City- New Brunswick
Peter	Chen	Advocates for Children NJ
Joshua	Cohen	Jewish Federation
Ronsha	Dickerson	Camden We Choose
Rev Eric	Dobson	SFair Share Housing
Rev Raymond	Fawole	Association of African Clergy
Christian	Fuscarino	Garden State Equality
Kiran	Gaudioso	United Way Northern New Jersey
Susan	Haspel	Boys & Girls Clubs in New Jersey
Elaine	Helms	Rain Foundation
Renee	Koubiadis	Anti-Poverty Network of New Jersey
Adele	LaTourette	Hunger Free New Jersey
Rev Sara	Lilja	Lutheran Episcopal Advocacy Ministry of New Jersey
Wendy	Martinez	New Jersey Coalition of Latino Pastors and Ministers

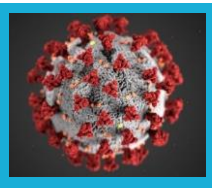


NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Michael	McCarthy	International Longshoreman's Association
Rev Marilyn	Mornoe Harris	United Missionary Baptist Convention of New Jersey
Salah	Mustafa	Islamic Center of Passaic County
Bishop Joshua	Rodriguez	National Latino Evangelical Coalition, New Jersey Coalition of Latino Pastors and Minsters
Carlos	Rodriguez	Community FoodBank of New Jersey
Rev. Louis	Roundtree	Newark office of Clergy Affairs
Phyllis	Salowe-Kay	New Jersey Citizen Action
Avi	Schnall	Agudath Israel of America
Rev. Dr. Danny	Scotton	Alpha Baptist Church
Rev. John	Taylor	Friendship Baptist Church
Rev. Lester	Taylor	General Baptist Convention of New Jersey
Imam	Uhmar	Salahuddin Pleasantville
Cecelia	Zalkind	Advocates for Children of New Jersey
Wei Han	Zhou	Community Options



Tourism and Entertainment

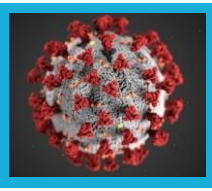
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Curtis	Bashaw	Congress Hall
Ray	Brogan	Recreational Fishing Alliance
Steve	Callender	Casino Association of New Jersey
Brian	Cheripka	iStar Development
Vicki	Clark	NJ Tourism Industry Association
Dennis	Drazin	Monmouth Park
Haime	Elhai	New York Jets
Curtis	Farrow	Irving Street Rep
Jarrod	Grasso	NJ Realtors
Peter	Guelli	New York Giants
Jeff	Gural	GFP Real Estate
Marilou	Halvorsen	NJ Restaurant & Hospital Association
Bishop	Hargrove	Atlantic City Minister Coalition
Amy	Herbold	Triple Five
Jim	Kirkos	Meadowlands Chamber
Dan	McCarthy	Lake Hopatcong Commission
Bob	McDevitt	Unite Here Local 54
Will	Morey	Morey Piers



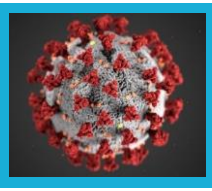
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Kevin	O'Brien	IATSE
Scott	O'Neil	Harris Blitzer Sports & Entertainment
Sheila	Reynertson	New Jersey Policy Perspective
Marilyn	Schlossbach	New Jersey Restaurant and Hospitality Association
Brendan	Sciarra	Cape May Brewing
Jon	Schreiber	NJPAC
Eric	Stiles	New Jersey Audubon Society
Ron	Vandeveen	Metlife Stadium
Peter	Ward	Hotel Trades Council
Roberto	Yañez	Univision

Transportation and Infrastructure

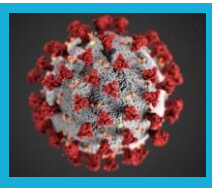
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Scott	Braen	Concrete and Aggregate Assoc
Robert	Briant	Utility and Transportation Contractors Association
Amit	Bose	HNTB, Coalition for Northeast Corridor
Nat	Bottigheimer	Regional Plan Association



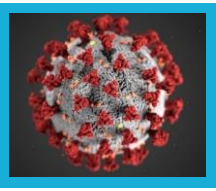
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Dave	Smith	UTCA
Alixon	Collazos	B Gill Group
Dennis	Daggett	International Longshoreman's Association - 1094
Jim	Fakult	Jersey Central Power & Light Company
Reva	Foster	New Jersey Black Issues Convention
Pam	Frank	Charge EVC
David	Gahl	Solar Energy Industry Association
Steve	Gardner	Laborers International Union of North America
Daniel	Gumble	International Brotherhood of Electrical Workers Local 164
Kim	Haneman	PSE&G
Jerome	Johnson	International Association of Sheet Metal Air Rail & Transportation
Jill	Kaplan	United Airlines
Glen	Kartalis	Council of Engineers
Jerry	Keenan	New Jersey Alliance for Action
Jack	Koscic	Associated Construction Contractors of New Jersey
Barry	Kushnir	IFPTE Local 194
Greg	Lalavee	Operating Engineers 825
Melissa	Lavinson	Pepco Holdings-Atlantic City Electric
Nadine	Leslie	Suez Water



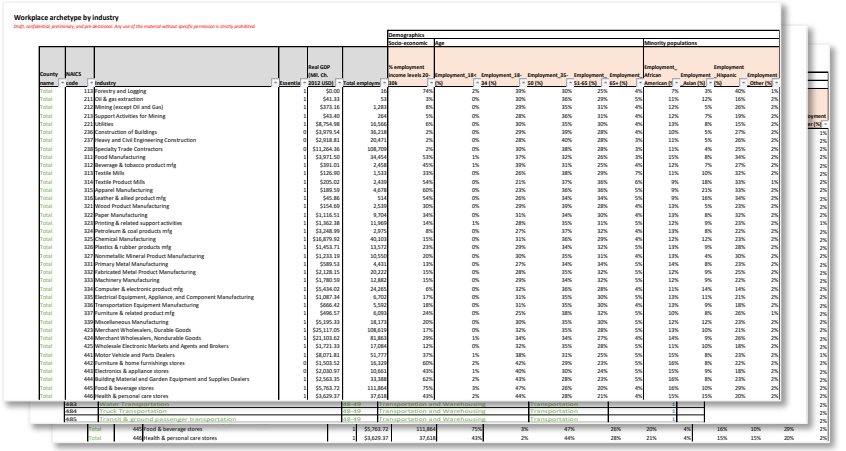
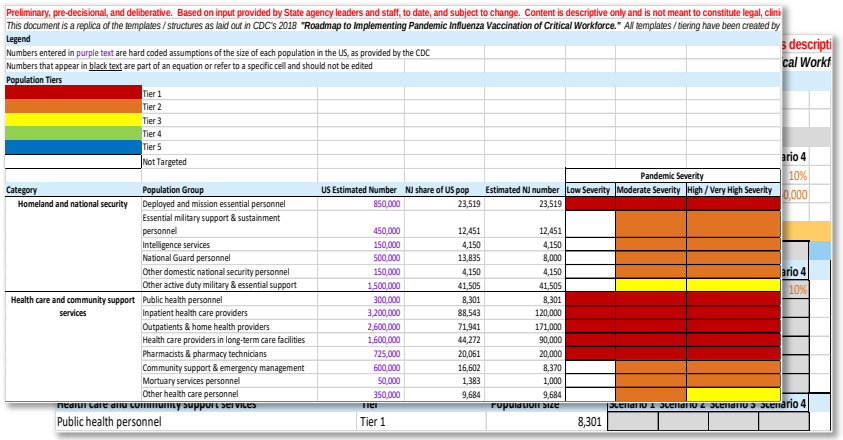
NJ Commission (Co-chairs: Zakiya Smith Ellis, Tim Sullivan, Jose Lozano)		
First Name	**Last Name**	**Organization**
Ev	Liebeman	AARP
Ali	Maher	Center for Advanced Infrastructure & Transportation
Yusuf	Mehta	Rowan University
Lauren	Moore	Atlantic County Economic Alliance
John	Nardi	New York Shipping Association
Cheryl	Norton	American Water
Fred	Potter	Teamsters
Mike	Renna	South Jersey Industries
Orlando	Riley	Amalgamated Transit Union
Nick	Sifuentes	Tri State Transportation Campaign
Scott	Sprengel	Executive VP of Coach USA and VP of the BANJ
Rick	Thigpen	PSE&G
Fred	Warner	AECOM
Steve	Westhoven	NJ Natural Resources
Ray	Woodall	Ironworkers 11
Charlie	Wowkanech	NJ AFL-CIO



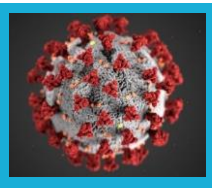
Section C: Preliminary Population Sizing



C.1. Overview of New Jersey Population Modeling

	Activities completed	Outputs
Population sizing	▪ Sizing each population sub-group ▪ Mapping demographic and socio-economic spread across sub-groups	
Grouping and tiering	▪ Grouping population based on CDC guidance ▪ Tiering will be required based on allocation guidance	

Preliminary, pre-decisional, and deliberative. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.



C.2. Preliminary Population Estimates for each Phase per CDC Playbook issued 9/16/2020

Phase	Category	Targeted populations	CDC/CISA estimates for NJ
Phase 1A	Health care workers with direct or indirect exposure	Inpatient health care providers	175,740
		LTC staff	94,510
		Outpatient/home health providers	227,130
		EMS	5,193
		State and local public health personnel	1,067
		Phase 1A subtotal	**503,640**
Phase 1B	Other essential workers	Food & agriculture, transportation, education, energy, water, law enforcement, government, etc.	776,150
	Adults with medical conditions at higher risk for severe COVID 19	Over age 65 or nursing home resident	1,509,251
		COVID-19-relevant chronic condition (COPD, obesity, CKD, etc.)	2,551,291
	Correcting for overlapping populations	*E.g. HCW with chronic condition, over-65 with chronic condition*	*-1,072,543*
		Phase 1B subtotal	**3,764,149**
		Phase 1A & B subtotal	**4,267,789**
Phase 2	After Phase 1 complete, expand access to general population	Remaining general population	4,614,401
		Total	8,882,190

179,943 health care workers are over age 65 or have a chronic condition

Timeline

First tranche
~83,100 doses would cover 8% of Phase 1a

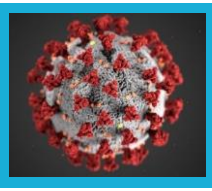
Second tranche
~831,000 doses brings Phase 1a to 91% completion

Third tranche~1,246,500 doses completes Phase 1a and brings Phase 1b to 15% completion

Combined 2,160,600 doses immunize 1,080,300 individuals, covering **12% of NJ population**

Assumes 2 doses to immunize 1 individual

Sources:
Phase descriptions: CDC COVID-19 Vaccination Program Interim Playbook (Sept. 16, 2020) and playbook-cited ACIP Prioritization work group considerations
Population groups and estimates: CDC and CISA aggregation of data provided to NJ DOH Sept. 15, 2020; underlying data gathered from Bureau of Labor Statistics, US Census, BRFSS, American Hospital Assn., and others
Timelines: Combines Scenarios A & B from CDC COVID-19 Vaccination Scenarios for Jurisdictional Planning (Aug. 27, 2020), and assumes vaccines allocated by population (i.e., NJ receives 2.77%)



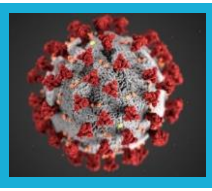
Section D: Preliminary metrics

D.1. Highly Preliminary Metrics for COVID-19 Vaccine Reporting and Tracking

	NJIIS Vaccine Coverage & Provider Info	VTrckS Vaccine Distribution & Accountability	VAERS/Epi-X Adverse Events	CDRSS COVID Cases & Testing	Site reports Site capacity	Engagement platform Engagement	Public confidence Public confidence
Metrics Generated	% Coverage (Doses Admin/Pop) Vax Effectiveness % 2 Doses, % 1 Dose Inter-dose interval # Providers Administering % Providers Enrolled (incl. pharmacies) % Missing Data by Provider **DATA CUTS** Age Race/Ethnic Sex Priority Group County Muni	Available (on-hand) Transferred (from NJIIS) Administered (from NJIIS) Wasted Expired/Spoiled Unaccounted for Returned shipment Over-estimated Shipped to Providers **DATA CUTS** CVX Provider County Muni	# Adverse Events % Doses w/ Adverse Event **DATA CUTS** Age Race/Ethnic Sex Priority Group County Muni	Case Rate / 1000 % Positivity % COVID-like Illness Case Fatality Rate # Deaths Hotspots	Potential site capacity Equipment, PPE, supplies, staff available / required Total slots total, filled, not filled, no show	People contacted / percent of populations contacted Number of appointments scheduled (1st dose, 2nd dose) Number of people declined / percent of people contacted who declined	Consumer calls Consumer confidence index Key topics
Key Variables for Calculating Metrics	**PROVIDER** Name & ID Location Address Facility NJIIS ID Facility Type (incl pharmacies) **SUBSTANCE** Lot Number Manufacturer Expiration Date CVX (Product) Adverse Event **ADMINISTRATION** Date Vax Admin Site Route of Admin Dose Number Dose Amount/Units Completed / Refused & Reason **PATIENT** NJIIS ID First & Last Name Sex Address (incl County & Muni) Race & Ethnicity DOB Occupation Employer type Membership in critical occupational groups Chronic conditions	**LOT-LEVEL** Lot Number Manufacturer (Product) Expiration Date Transaction Date Volume/Dose Presentation (Vial, Syringe, etc.) Funding Source (VFC, 317, private, etc.) Quantity Provider Facility Time to expiration	**PATIENT** Name (optional) Address (optional) DOB Date of Vax Sex Vaccine Race/Ethnicity (optional) **SUBSTANCE** Manufacturer Product Lot Number Route Body Site Dose Number **EVENT** Result/Outcome Description	**PATIENT** Name Address (incl County & Muni) DOB Sex Case Status Serology Result RT-PCR Result Date of Death Date of Onset	**PROVIDER** Name & ID Location Address Facility (facility #)—*Determine whether NJIIS Facility ID is in VTrckS* Equipment, PPE, supplies, staff available / required Total slots total, filled, not filled, no show	**PATIENT** Name (optional) Address (optional) DOB Date of Vax Sex Vaccine Race/Ethnicity (optional) Occupation Employer type Person contacted / scheduled / declined	**PATIENT** Municipality (optional) County (optional) Age Range (optional) Sex (optional) Occupation (optional) Employer type (optional) Topic/concern
Matching Variables	Lot Number First & Last Name DOB Vax Date NJIIS Facility ID	Lot Number (not available for some data) Facility (facility #)—*Determine whether NJIIS Facility ID is in VTrckS*	Lot Number (optional) First & Last Name (optional) DOB (required) Vax Date (required)	First & Last Name DOB	Facility (facility #)—*Determine whether NJIIS Facility ID is in VTrckS*	First & Last Name DOB	

Source: https://repository.immregistries.org/files/resources/587555d1b2156/mi_-_inventory_management.pdf

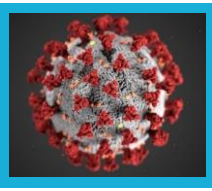
Preliminary, pre-decisional, and deliberative. Based on input provided by State agency leaders and staff, to date, and subject to change. Content is descriptive only and is not meant to constitute legal, clinical, or policy advice.



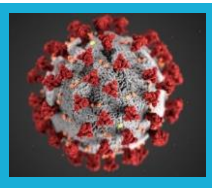
Section E: Overview of Current and Potential Vaccine Administrators in New Jersey

E.1. Current Scopes of Practice for Licensed Professionals to Administer COVID-19 Vaccine (As of 10/2020)

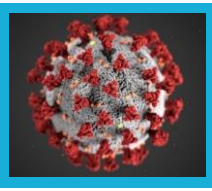
Board	License/ Occupation	Can Administer?	Authority to Administer	Limitations on Authority	Active Licenses
Medical Examiners	Physician	**Yes**	No specific statute or regulation referencing administration of vaccinations, but clearly within the scope of practice for plenary licensed physicians (M.D., D.O.).		**40,808**
Medical Examiners	Physician Assistant	**Yes**	N.J.S.A. 45:9-27.16(b)(2) and N.J.A.C. 13:35-2B.4(b)(2) PAs can give injections and administer medications if directed by supervising physician or if part of delegation agreement with physician. Delegation agreement requirement is waived during the Public Health Emergency pursuant to EO 112 and DCA AO 2020-02.		**4,165**
Midwifery	Certified Nurse Midwife	**Yes**	No specific statute or regulation referencing administration of vaccinations.	All midwives must have clinical guidelines with affiliated physician. NJAC 13:35-2A.6. For	**682**



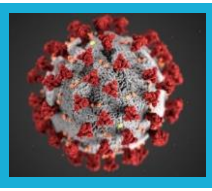
				CNMs, this includes a listing of the categories of drugs that they can prescribe/order/administer/dispense. For certified nurse midwives who do not hold prescriptive authority, the clinical guidelines shall include list of medication that licensee can administer and dispense.	
Nursing	Advanced Practice Nurse	**Yes**	See N.J.S.A. 45:11-49; NJAC 13:37-7.9. APNs must have written joint protocols for the prescriptions of medications and devices with collaborating NJ physicians. (NJAC 13:37-7.9A, NJAC 13:37-10) Written joint protocol requirement is waived during the Public Health Emergency pursuant to EO 112 and DCA AO 2020-02.		**10,702**



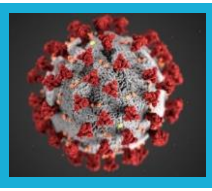
Midwifery	Certified Midwife	**Yes**	No specific statute or regulation referencing administration of vaccinations.	All midwives must have clinical guidelines with affiliated physician. NJAC 13:35-2A.6. For CMs, the clinical guidelines shall include list of medication that licensee can administer and dispense.	**14**
Midwifery	Certified Professional Midwife	**Yes**	No specific statute or regulation referencing administration of vaccinations.	All midwives must have clinical guidelines with affiliated physician. NJAC 13:35-2A.6. For CPMs, the clinical guidelines shall include list of medication that licensee can administer and dispense.	**14**



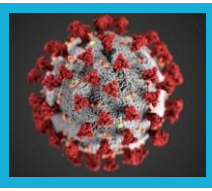
Dentistry	Dentist	**Yes***	Dentists are defined, at N.J.S.A. 26:13-2, as "health care providers" in the Emergency Health Powers Act (N.J.S.A. 26:13-1, et seq.). If directed by the Commissioner of Health pursuant to the EHPA, dentists could be authorized to administer vaccinations during a state of public health emergency (N.J.S.A. 26:13-18a). If scope of practice is expanded under extant EOs or AOs, dentists have the training to administer vaccines. Dentists are trained to obtain an accurate and relevant medical history and address adverse reactions, though additional training on vaccines should be made available before. Whether scope should also be expanded to include prescribing or ordering vaccines is a policy call. Delegation to dental auxiliaries not recommended.		**8,907**
Medical Examiners	Bioanalytical Laboratory Directors/Specialty	**Yes***	Any NJ licensed Bioanalytical Laboratory Director/Specialty who is also a NJ licensed physician, is authorized to administer vaccines pursuant to N.J.S.A. 45:9-5.1, "…the practice of medicine shall include any method of treatment of human ailment, disease, pain…..". (N.J.S.A. 45:9-42.7; N.J.A.C. 45:9-5.1; and N.JA.C. 13:35-3.6) Bioanalytical laboratory directors/specialty are defined, at N.J.S.A. 26:13-2, as "health care providers" in the Emergency Health Powers Act (N.J.S.A. 26:13-1, et seq.). If directed by the Commissioner of Health pursuant to the EHPA, bioanalytical laboratory directors/specialty could be	A NJ licensed Bioanalytical Laboratory Director/Specialty who is not a NJ licensed physician is not authorized to prescribe/order or administer vaccines. These individuals will have a PHD, MA or BA in a scientific field	**402**



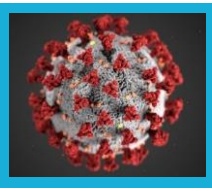
			authorized to administer vaccinations during a state of public health emergency (N.J.S.A. 26:13-18a).	such as chemistry, biological sciences, among others.	
Medical Examiners	Certified Medical Assistant	**Yes**	CMAs are authorized to administer (but not prescribe/order) vaccines when a physician is on the premises and is within a reasonable proximity of the treatment room and available to observe, assess and take any necessary action regarding effectiveness, adverse reaction or any emergency. (N.J.A.C. 13:35.6.4)		
Nursing	CHHA	**Yes**	CHHAs are persons employed by a home care services agency and who is performing delegated nursing regimens or nursing tasks delegated by RNs. See N.J.S.A. 45:11-23(c) and N.J.A.C. 13:37-14.3.		**55,171**
Nursing	LPN	**Yes**	LPNs scope of practice, found in N.J.S.A. 45:11-23, is defined as performing tasks and responsibilities within the framework of casefinding, etc., under the direction of a registered nurse or licensed physician or dentist, or APN.		**23,404**



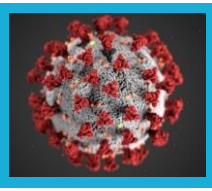
Nursing	RN	**Yes**	N.J.S.A. 45:11-23 authorizes RNs to, among other things, treat human responses to actual physical health problems, provide care supportive to or restorative of life and well being and execute medical regimens as prescribed by MD, DO or dentist and APN (NJSA 45:11-49(a). Also see N.J.A.C. 13:37-6.2(a), 6.4 and 6.5.		**134,433**
Nursing	Unlicensed Nursing Personnel	**Yes**			
Perfusionist	Perfusionist	**Yes***	Persusionists are defined, at N.J.S.A. 26:13-2, as "health care providers" in the Emergency Health Powers Act (N.J.S.A. 26:13-1, et seq.). If directed by the Commissioner of Health pursuant to the EHPA, perfusionists could be authorized to administer vaccinations during a state of public health emergency (N.J.S.A. 26:13-18a).		**195**
Pharmacy	Pharmacist	**Yes**	Pharmacists must be pre-approved after Board review of qualifications and then can administer vaccines to ages 18 and over pursuant to prescription, standing order or national vaccine program. Flu vaccines may be administered to ages 7 and up (prescription required for ages 7-9). (N.J.S.A. 45:14-63 and N.J.A.C. 13:39-4.21)	18 and over for all vaccines; 7 and over for flu vaccine (prescription required for ages 7-9	**18,482**
Pharmacy	Pharmacy Extern	**Yes**	Pharmacy externs – Same as interns, except because they do not register with the Board, the supervising pharmacist is	18 and over for all vaccines; 7 and over for flu vaccine	



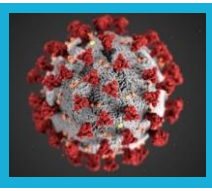
			responsible for ensuring they have the proper training to administer vaccines	(prescription required for ages 7-9	
Pharmacy	Pharmacy Intern	**Yes**	Pharmacy interns permited to administer vaccines under direct supervision of a pharmacist and if they meet criteria for education and training set forth in regulations jointly promulgated with BME. Regs not yet published as a proposal, with an AO pending. (N.J.S.A. 45:14-63)	18 and over for all vaccines; 7 and over for flu vaccine (prescription required for ages 7-9	**101**
Respiratory Care	Respiratory Therapist	**Yes***	Respiratory care practitioners are defined, at N.J.S.A. 26:13-2, as “health care providers” in the Emergency Health Powers Act (N.J.S.A. 26:13-1, et seq.). If directed by the Commissioner of Health pursuant to the EHPA, respiratory therapists could be authorized to administer vaccinations during a state of public health emergency (N.J.S.A. 26:13-18a). Respiratory Care Therapists currently do not have the training to administer vaccines and would likely need training before they could be relied upon to administer vaccinations.		**3,449**
Acupuncture	Acupuncturist	**No**			**1,153**
Athletic Training	Athletic Trainer	**No**			**1,587**



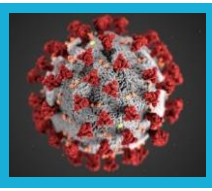
Audiology and Speech Language Pathology	Audiologists & Speech-Language Pathologist	**No**			**7,450**
Chiropractic Examiner	Chiropractor	**No**	NJAC 13:44E-3.3 - Chiropractors shall not perform needle EMG or any test requiring administration of medication.		**3,282**
Marriage and Family Therapy	Alcohol and Drug Counselor	**No**			**3,018**
Marriage and Family Therapy	Marriage and Family Therapist	**No**			**560**
Medical Examiners	Electrologist	**No**			**132**
Medical Examiners	Genetic Counselor	**No**			**385**
Medical Examiners	Hearing Aid Dispenser	**No**			**746**
Medical Examiners	Podiatrist	**No**			**1,252**



Occupational Therapy	Occupational Therapists/ Assistant	**No**			**8,710**
Ophthalmology	Ophthalmic Dispenser/Technician	**No**			**1,546**
Optometry	Optometrist	**No**		It is also argued that Optometrists are not authorized to order or prescribe the Covid vaccine under the scope of practice as the purpose of the vaccine is not to treat an eye condition or a disease affecting the eyes.	**1,592**
Orthotics and Prosthetics	Orthotists/Prosthetist	**No**			**215**
Pharmacy	Pharmacy Technician	**No**			**16,163**

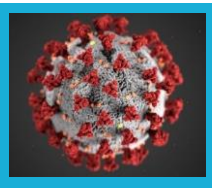


Physical Therapy	Physical Therapist	**No**	Physical Therapists do not have training to administer injections in their professional educational programs.		**11,241**
Polysomnographic Technologists	Polysomnographic Technologist/Technician/Trainee	**No**			**401**
Professional Counselor	Professional Counselor	**No**			**5,139**
Psychoanalysis	Psychoanalyst	**No**			**33**
Psychology	Psychologist	**No**	A discussion with the Chair of the Board of Psychological Examiners confirmed that current psychologist's doctoral programs do not provide training in administering injectable pharmaceutical agents.		**3,677**
Social Work	Social Worker	**No**			**22,362**
Veterinary	Veterinarian	**No**			**3,244**



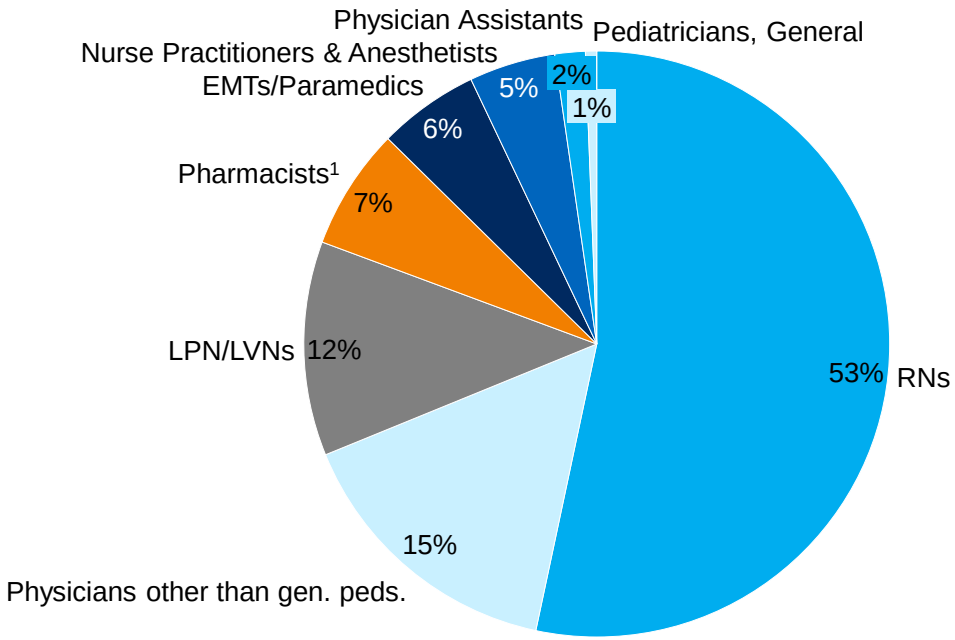
Medical Examiners	Medical Student	?	The decision as to whether medical students would be able to administer vaccinations would be determined by the hospitals at which they are rotating through during their clinical clerkships in their 3rd and 4th year of school (not the Board). The DOH may also be involved in this decision-making process since they oversee the hospitals.		
Medical Examiners	Resident	?	The decision as to whether residents (PGY1 and above) would be able to administer vaccinations would be determined by the hospitals at which they are rotating through during their residencies (not the Board). The DOH may also be involved in this decision-making process since they oversee the hospitals.		**2,620**

* Authority to administer granted by Emergency Health Powers Act (N.J.S.A. 26:13-1, et seq.). If directed by the Commissioner of Health pursuant to the EHPA, licensee could be authorized to administer vaccinations during a state of public health emergency (N.J.S.A. 26:13-18a).



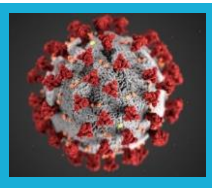
E.2. Estimates of Potential Vaccine Administrators in New Jersey

% of potential vaccine providers, by occupation



Occupation	Estimated number
RNs	80,140
Physicians other than general pediatricians	23,280
LPN/LVNs	17,770
Pharmacists[1]	10,080
EMTs/Paramedics	8,370
Nurse Practitioners & Anesthetists	7,160
Physician Assistants	2,520
Pediatricians, General	930
Total	**150,250**

Source: Bureau of Labor Statistics, Occupational Employment Statistics Survey May 2019
1. May require legislative action to authorize COVID-19 vaccine administration; Does not include ~500 pharmacist interns

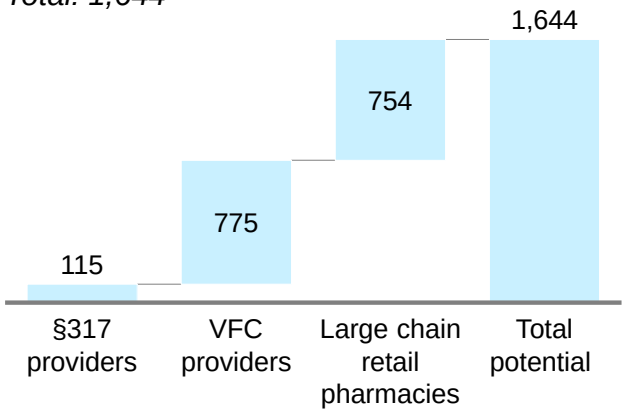


Section F: Overview of Current Vaccine PODS in New Jersey Registered in NJIIS

F.1. Current Number of NJIIS Interface Profiles by Organization Type (as of 9/2020)

Potential vaccination provider sites

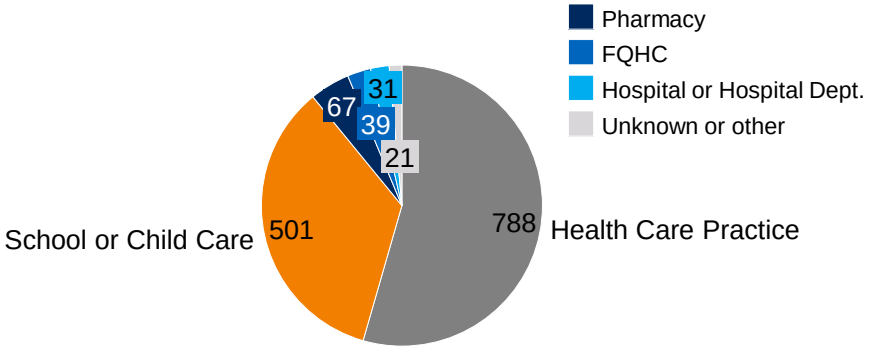
Total: 1,644



Adding large chain retail pharmacies would nearly double capacity

Current NJIIS interface profiles, by type of organization

Total: 1447



Source: NJDOH data (IIS profiles, VFC and §317 providers); Web scrape (large chain pharmacies)

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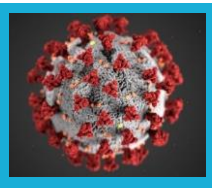

Section G: PODS Requirements

G.1. Types of PODS

Reach	**Closed** *(restricted for onsite employees/patients/residents)*	**Open** *(open to members outside the organization)*
Type	**Static**	**Mobile**
Funding	**Government led**	**Private**
Access	**Drive through**	**Walk-up** **Drive-up**
Throughput	**High throughput** *(site operational 6 days a week; each vaccinator does 12 vaccinations per hour)*	**Low throughput** *(site operational 5 days or less a week; each vaccinator does 6 vaccinations per hour)*

Examples:

Hospitals are static, mainly private, drive-up/ walk-up, high-throughput sites which could be closed or open

FQHC sites are static or mobile, government-led, walk-up / drive-up sites with low throughput which are typically open

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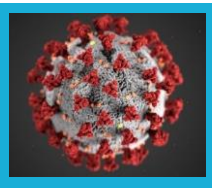

G.2. Planning considerations for ultracold storage

Ultracold storage availability	Vaccine dispensing site strategy	Timely administration	Second dosage options[1,2]	Reachable population
Limited or no ultracold storage	Limit vaccine dispensing sites to more **centralized locations (e.g., large hospitals)** Consider **heightened safety protocols** (e.g., maintain physical distance between those being vaccinated)	Require vaccination providers to administer vaccinations within **2 days of vaccine delivery** (assuming vaccine can be stored in the refrigerator)	Require vaccination providers to **use the entire shipment** each time they receive it	**Challenge for vaccination providers to gather non-captive populations** for one day intensive vaccinations
Widely available ultracold storage	Enable vaccines to be provided **in distributed locations (e.g., hospitals, pharmacies, mobile clinics, public health centers)**	Enable vaccines to be dispensed with **fewer time restrictions**	Allow vaccination providers the **flexibility to choose** between **reserving a portion of each shipment** for the second dose, or **using the entire shipment for first dose** and waiting to administer second dose until new shipment is received	Enable vaccination providers to **reach more populations**, both captive (e.g., healthcare professionals, the elderly) and non-captive (e.g., patients with comorbidities, teachers)

1. Vaccine administrators should ensure the second dose is the same vaccine as the first dose
2. Both doses must be given, with the second dose administered at the appropriate time; otherwise both doses need to be given again

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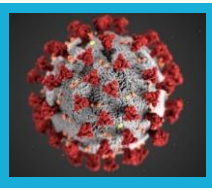
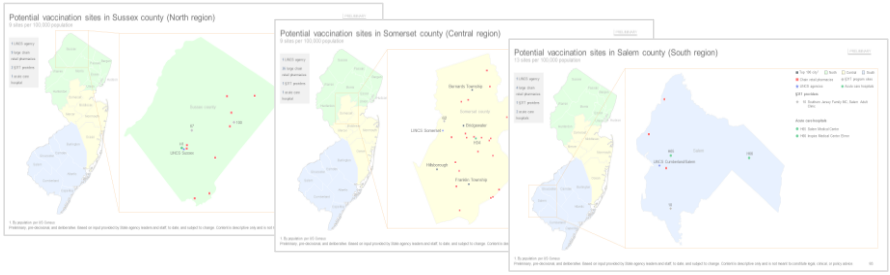
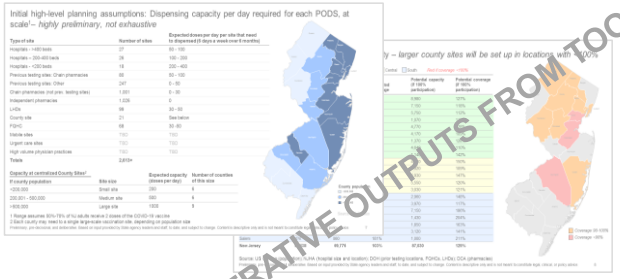
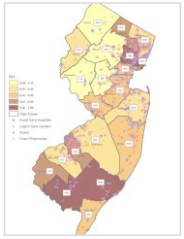
Source: CDC, Pfizer, USA Today, Fierce Pharma

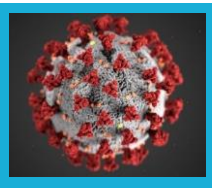


Section H: PODS Capacity Assessment

H.1. Geospatial tool to estimate required PODS capacity

	Steps	Outputs
Location of potential PODS	▪ Potential PODS have been identified and mapped at a county level including[1]: – Hospitals – Chain pharmacies – Independent pharmacies – Local Health Departments (LHDs) – FQHCs – Urgent care and high volume physician practices	
Capacity of potential PODS sized relative to required capacity	▪ Doses that can be dispensed per day per site have been estimated[2] ▪ Based on assumptions, degree of coverage available geographically has been calculated ▪ Large scale county-level vaccination sites may be planned to ensure sufficient coverage[2]	
Access for specific populations	▪ Planning for PODS includes specific population groups ▪ Social Vulnerability Index (SVI)[3] review to determine location of PODS sites ▪ Types of PODS expanded to provide sufficient access (e.g., mobile sites)	

1 Rollout of PODS may be sequenced based on prioritized population groups

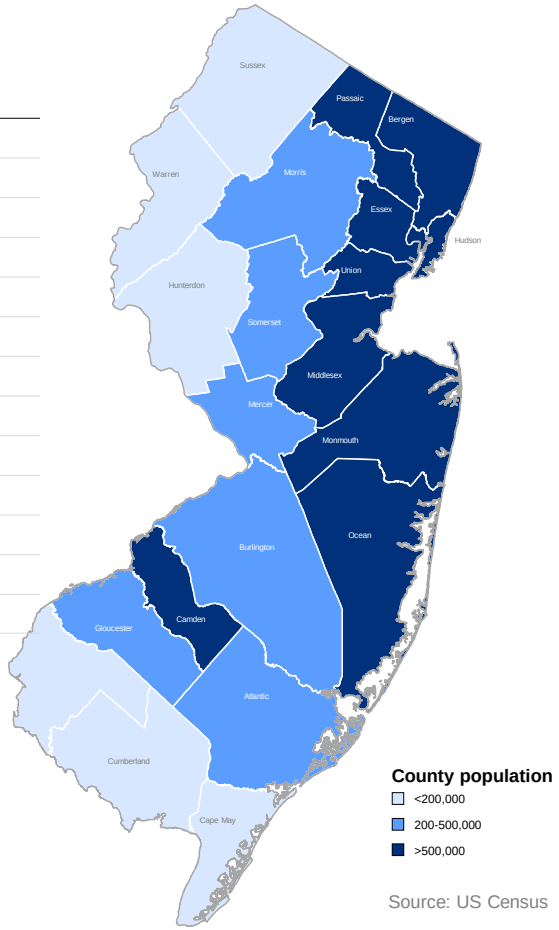


H.2. Initial high-level planning assumptions: Dispensing capacity per day required for each PODS, at scale[1]– *highly preliminary*, *not exhaustive*

Type of site	Number of sites	Expected doses per day per site that need to dispensed (6 days a week over 6 months)
Hospitals - >400 beds	27	50 - 100
Hospitals – 200-400 beds	26	100 - 200
Hospitals - <200 beds	18	200 - 400
Previous testing sites: Chain pharmacies	80	50 - 100
Previous testing sites: Other	247	0 - 50
Chain pharmacies (not prev. testing sites)	1,001	0 - 30
Independent pharmacies	1,026	0
LHDs	99	30 - 50
County site	21	See below
FQHC	68	30 -50
Urgent care sites	150+	TBD
Mobile sites	TBD	TBD
High volume physician practices	TBD	TBD
Totals	**2,613+**	

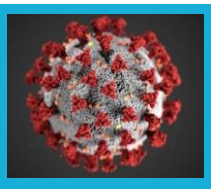
Capacity at centralized County Sites[2]

If county population	Site size	Expected capacity (doses per day)	Number of counties of this size
<200,000	Small site	200	6
200,001 - 500,000	Medium site	500	6
>500,000	Large site	1000	9



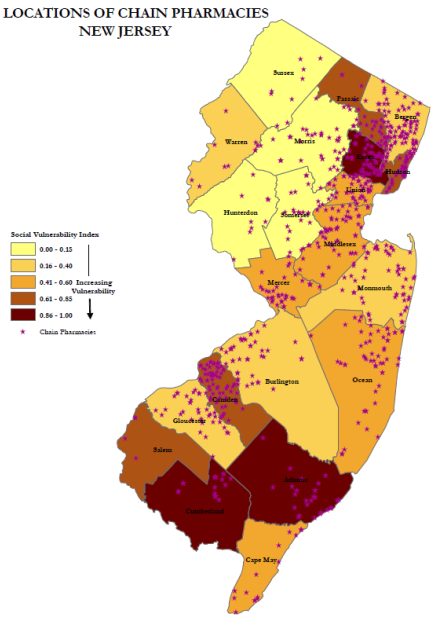
Source: US Census

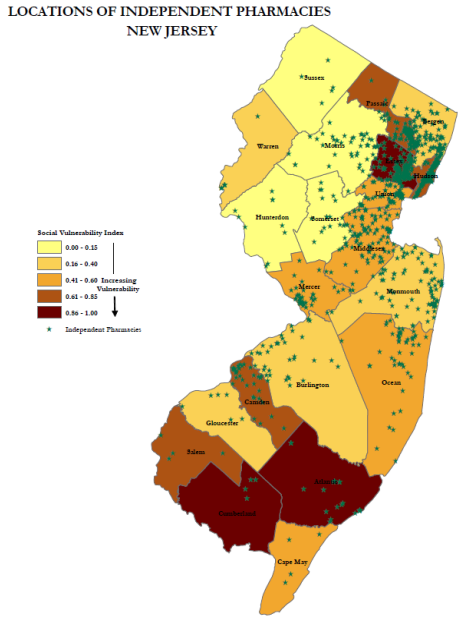
1 Range assumes 50%-70% of NJ adults receive 2 doses of the COVID-19 vaccine
2 Each county may need a single large-scale vaccination site, depending on population size



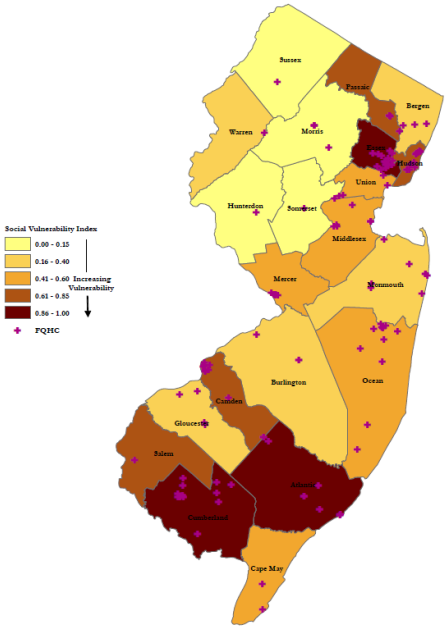
Section I: Geospatial mapping of potential PODS in the state against Social Vulnerability Index (SVI)

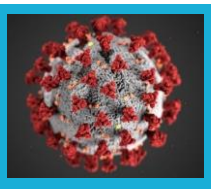
I.1. Map of pharmacies in NJ against SVI



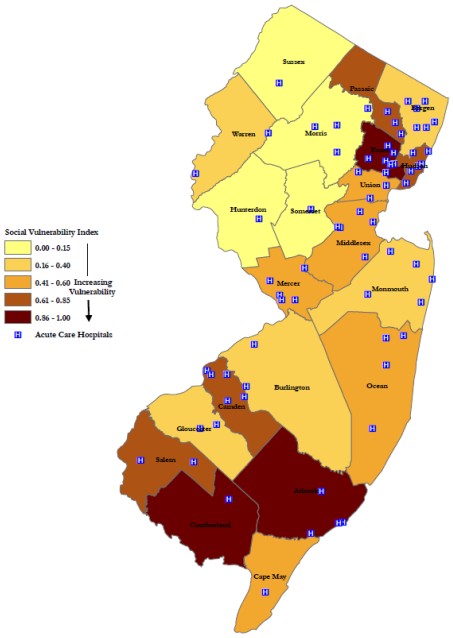


I.2.Map of Federally Qualified Health Centers (FQHCs) in NJ against SVI

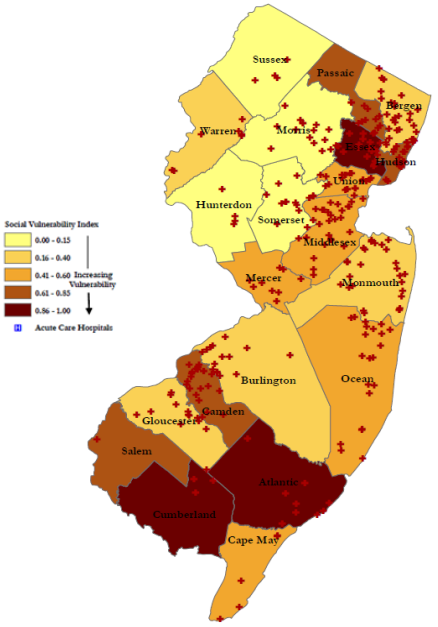


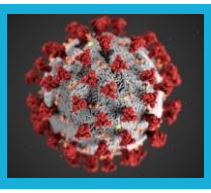


I.3. Map of Acute care hospitals in NJ against SVI

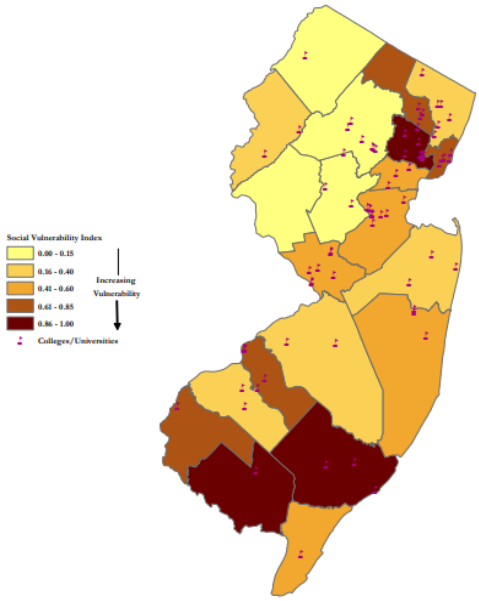


I.4. Map of Urgent care centers in NJ against SVI

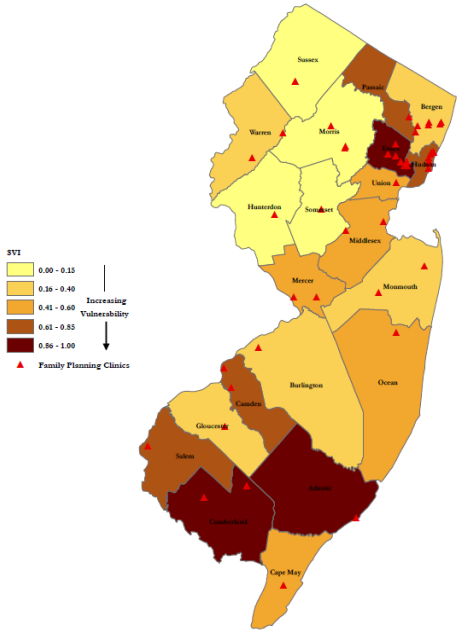


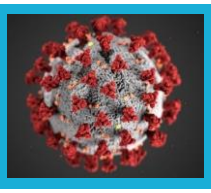


I.5. Map of colleges and universities in NJ against SVI

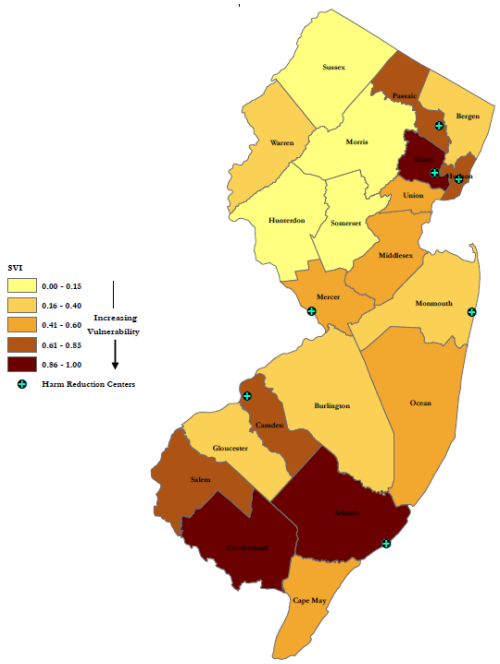


I.6. Map of Family Planning clinics in NJ against SVI





I.7. Map of Harm Reduction centers in NJ against SVI



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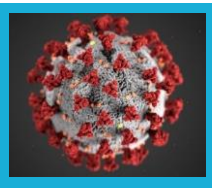
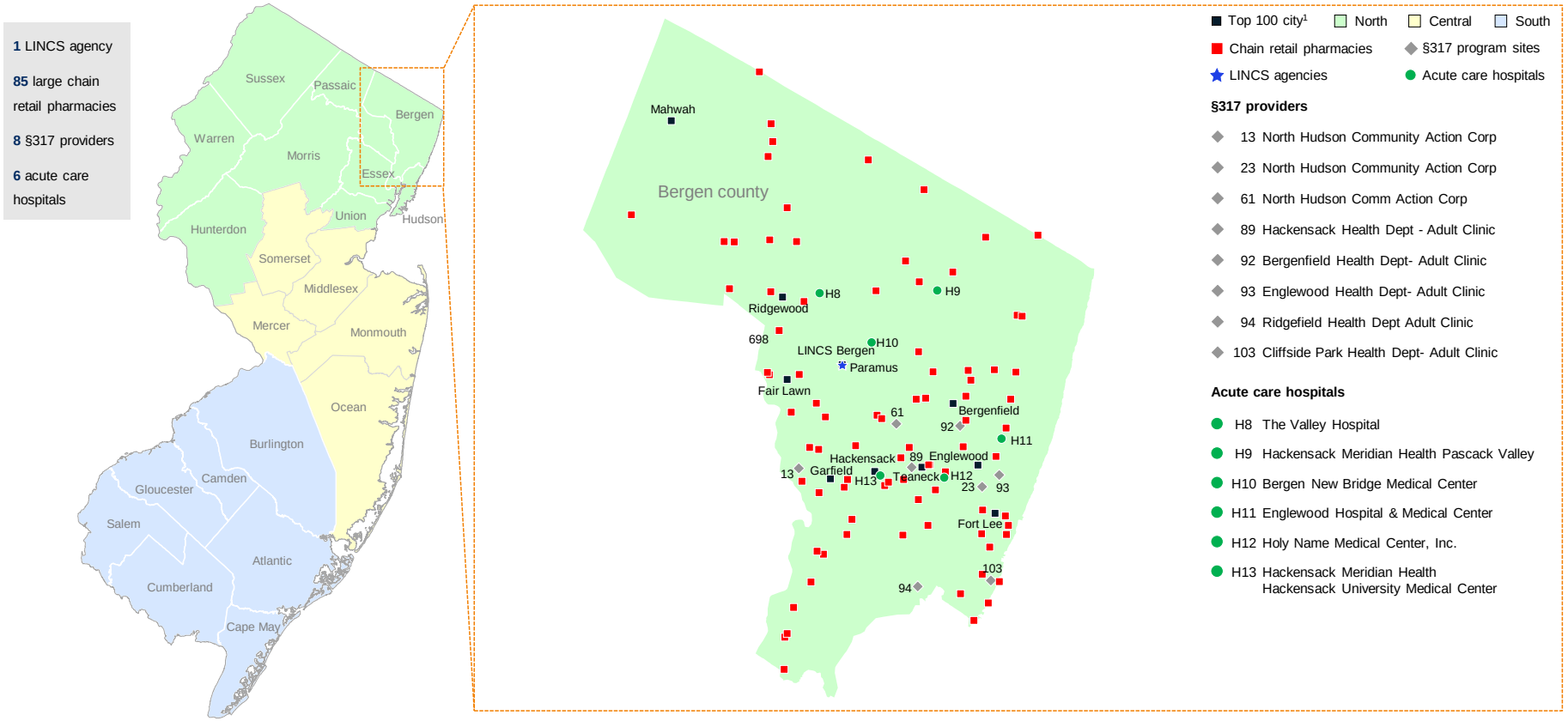


Section J: Geospatial mapping of potential PODS at a county level

J.1.a. Potential vaccination sites in Bergen County (Northern region)

11 sites per 100,000 population



1. By population per US Census

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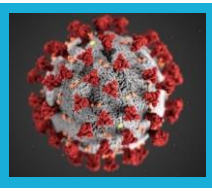


J.1.b. Potential vaccination sites in Essex County (Northern region)

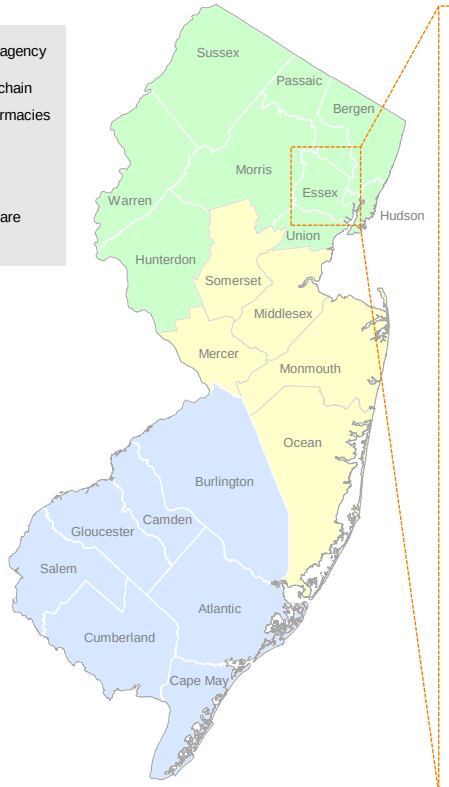
9 sites per 100,000 population

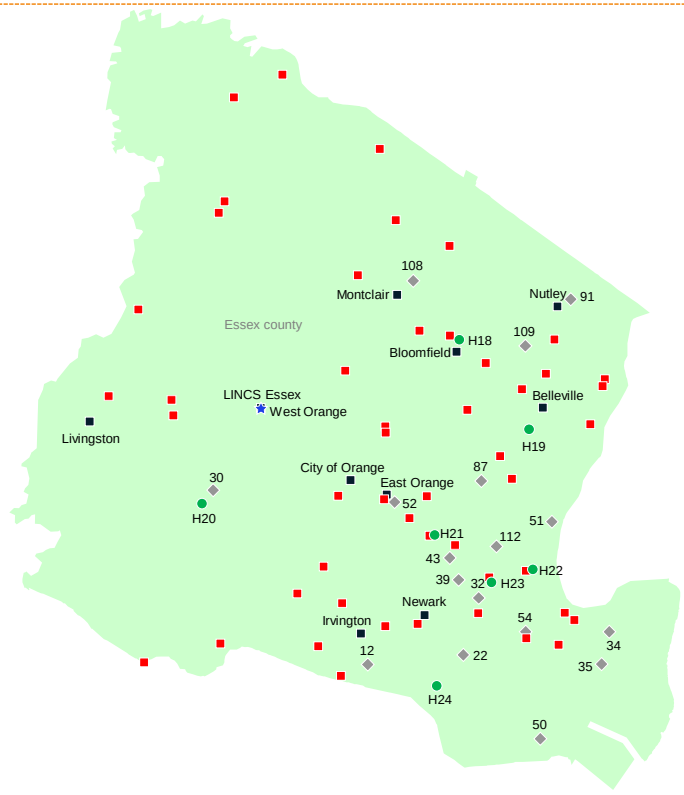
1 LINCS agency

49 large chain retail pharmacies

17 §317 providers

7 acute care hospitals





Top 100 city[1] | North | Central | South

Chain retail pharmacies | §317 program sites

LINCS agencies | Acute care hospitals

§317 providers

- 12 Newark Community Health Center
- 22 Central Health Center Jrmc Adult Clinic
- 30 Zufall Health Center West Orange Adult Clinic
- 32 Jewish Renaissance Medical Center 13Th
- 34 Saint James Health Adult Clinic
- 35 Newark Community Health Center Ferry
- 39 Rutgers Commuity Health Center
- 43 Saint James Health Ii Adult Ww
- 50 Newark Community Health Center,
- 51 Newark Community Health Center,
- 52 Newark Community Health Center
- 54 City Of Newark Dept. of Health & Community
- 87 East Orange Health Dept- Adult Clinic
- 91 Nutley Health Dept Adult Clinic
- 108 Montclair Health Dept Adult Clinic
- 109 Bloomfield Health Dept Adult Clinic
- 112 Essex Residential Program

Acute care hospitals

- H18 Hackensack Meridian Health
- H19 Clara Maass Medical Center
- H20 Saint Barnabas Medical Center, Inc
- H21 East Orange General Hospital Inc.
- H22 Saint Michael's Medical Center, Inc.
- H23 University Hospital
- H24 Newark Beth Israel Medical Center

1. By population per US Census

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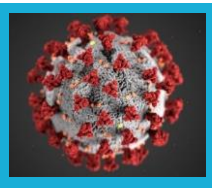


J.1.c. Potential vaccination sites in Hudson County (Northern region)

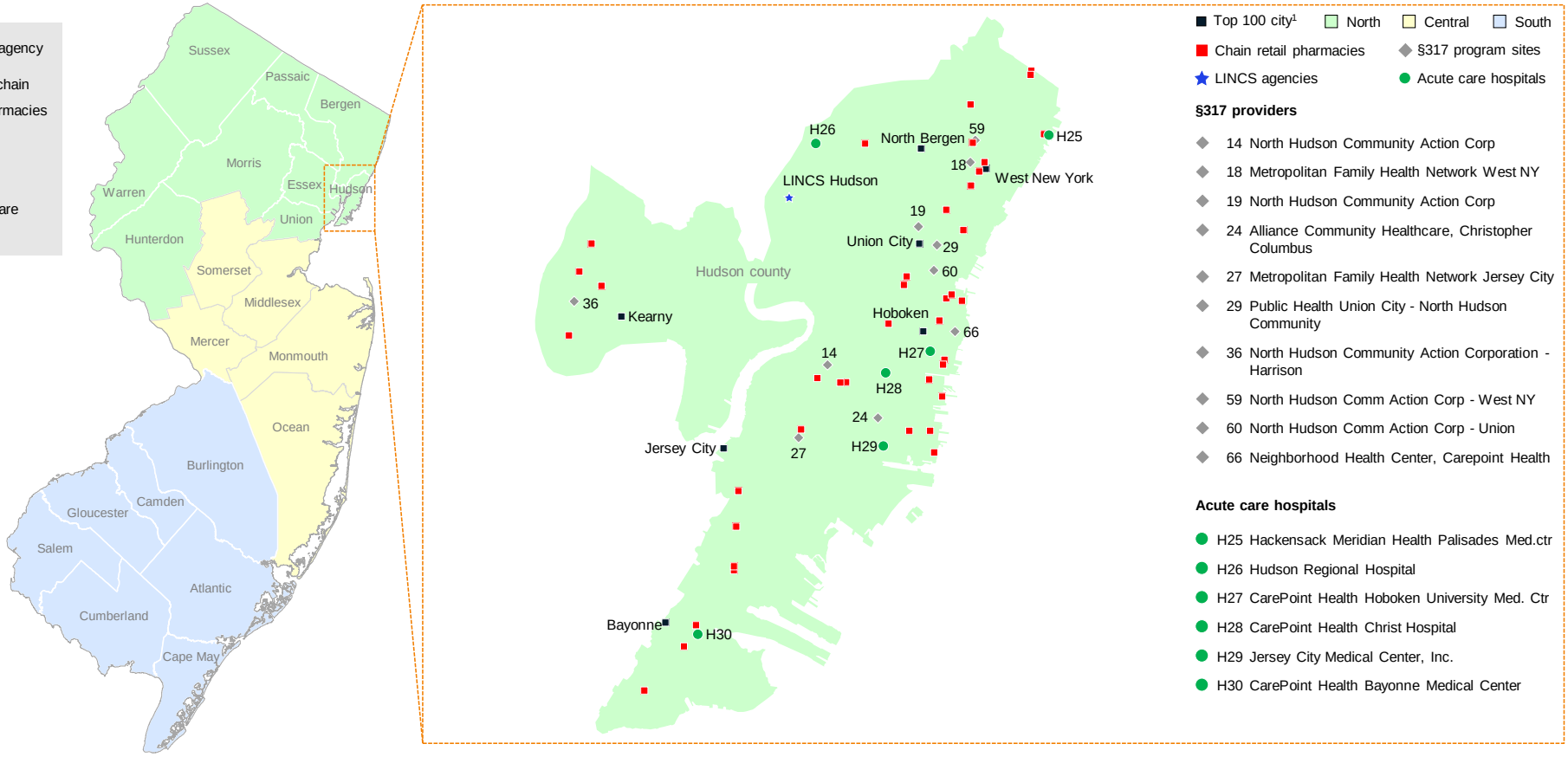
8 sites per 100,000 population

1 LINCS agency

40 large chain retail pharmacies

10 §317 providers

6 acute care hospitals



1. By population per US Census

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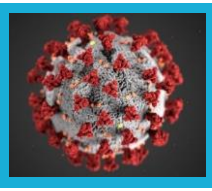


J.1.d. Potential vaccination sites in Hunterdon County (Northern region)

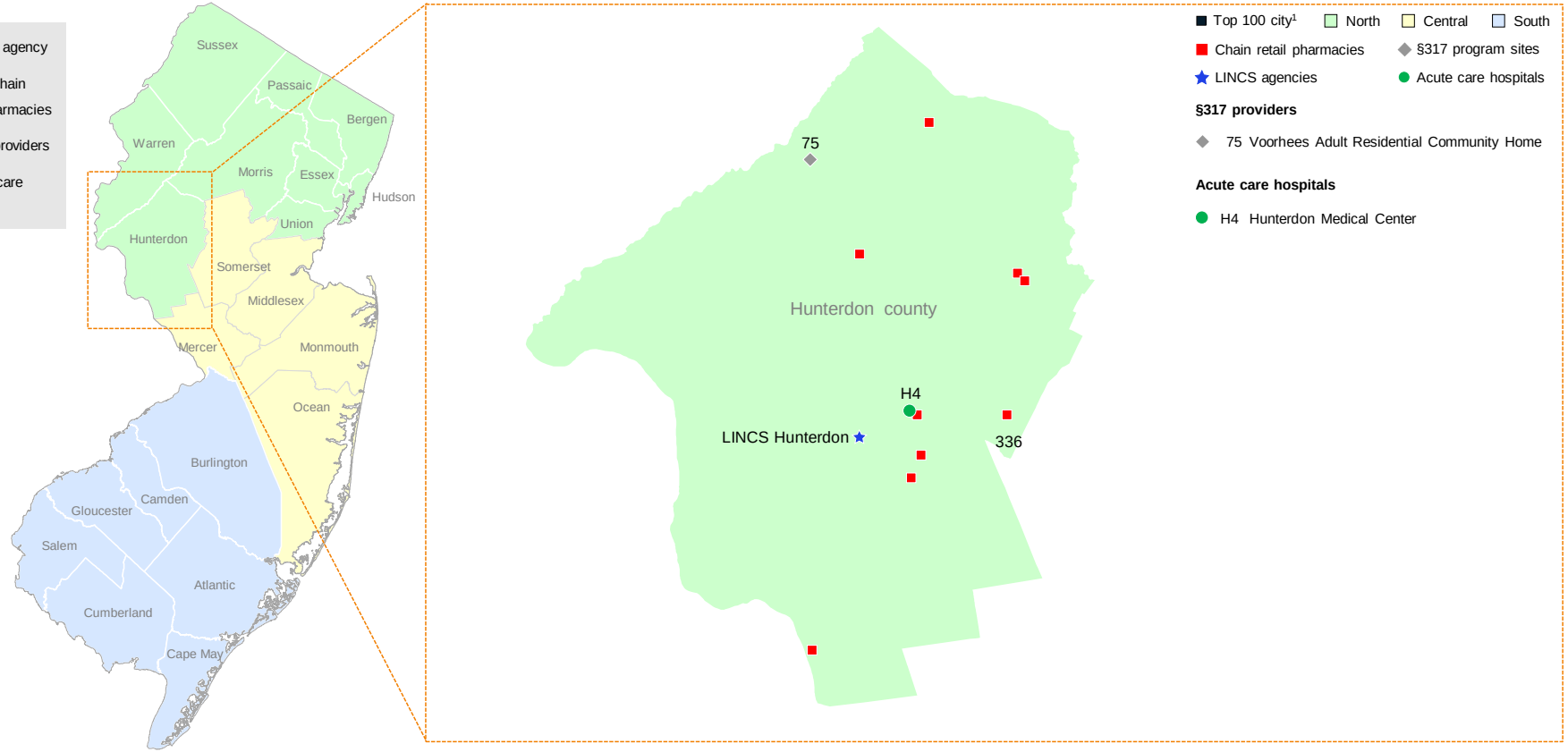
10 sites per 100,000 population

1 LINCS agency

9 large chain retail pharmacies

1 §317 providers

1 acute care hospitals



1. By population per US Census

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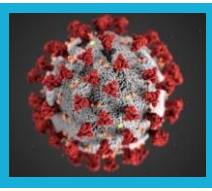
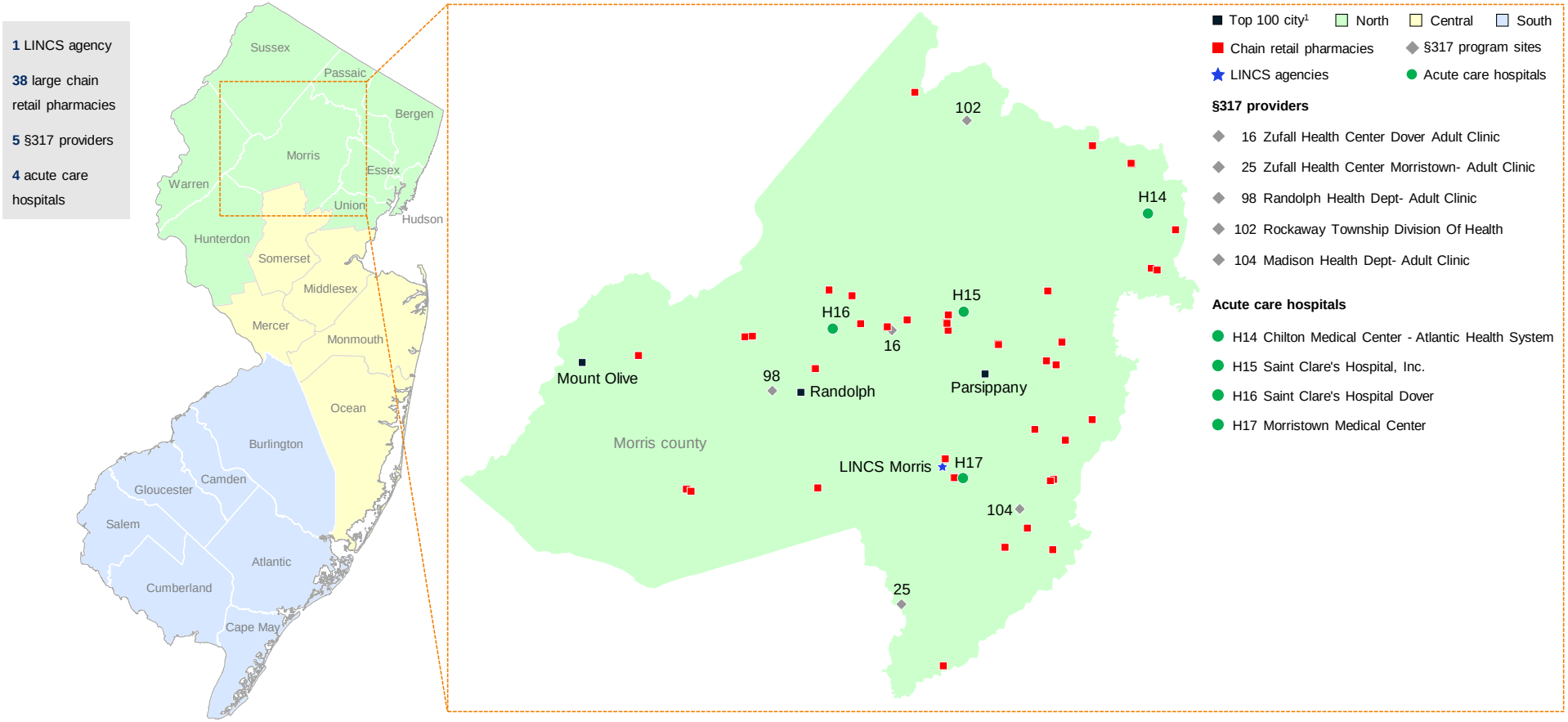


J.1.e. Potential vaccination sites in Morris County (Northern region)

10 sites per 100,000 population



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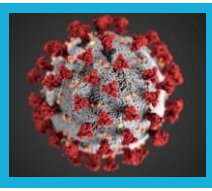


J.1.f. Potential vaccination sites in Passaic County (Northern region)

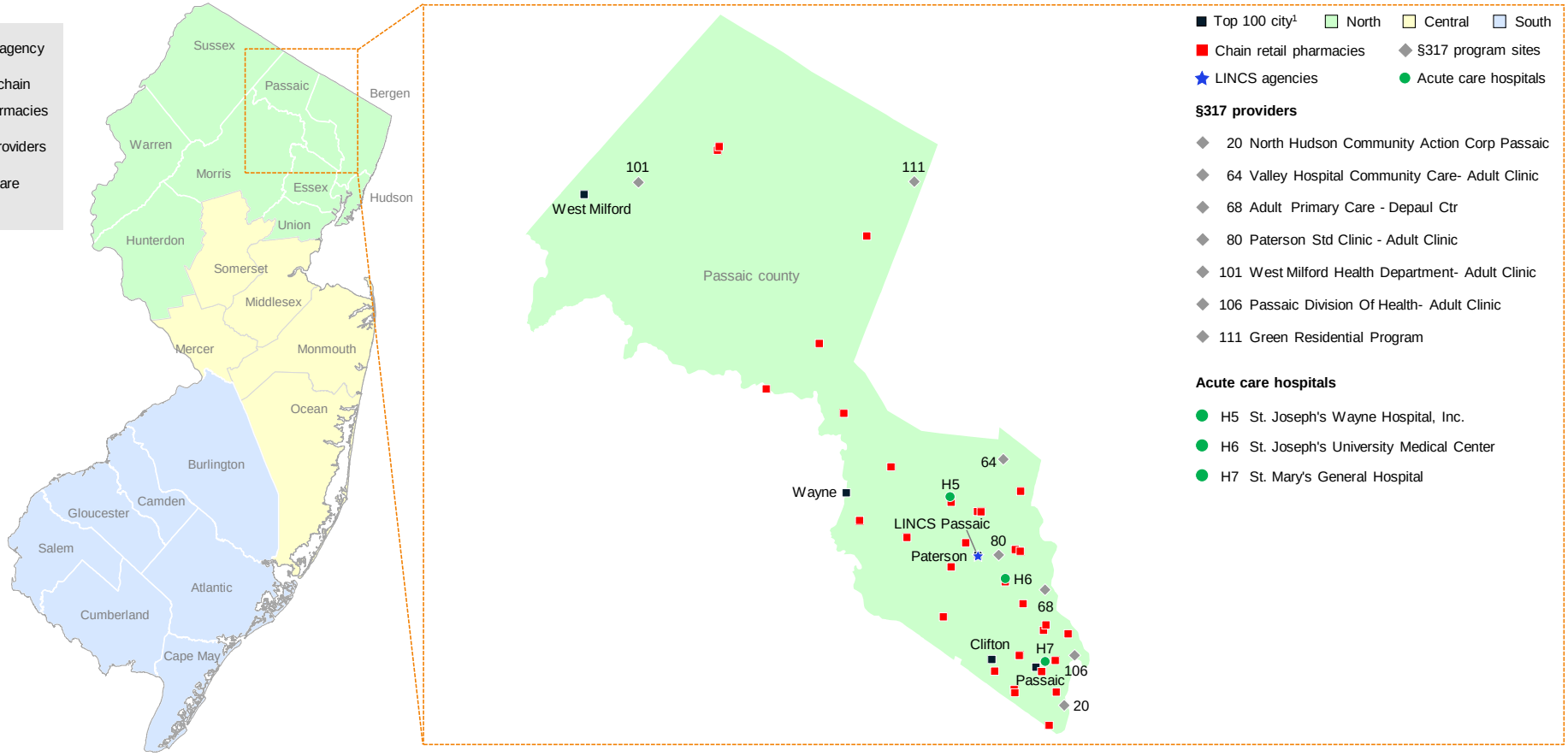
8 sites per 100,000 population

1 LINCS agency

31 large chain retail pharmacies

7 §317 providers

3 acute care hospitals



1. By population per US Census

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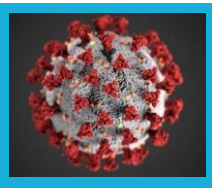


J.1.g. Potential vaccination sites in Sussex County (Northern region)

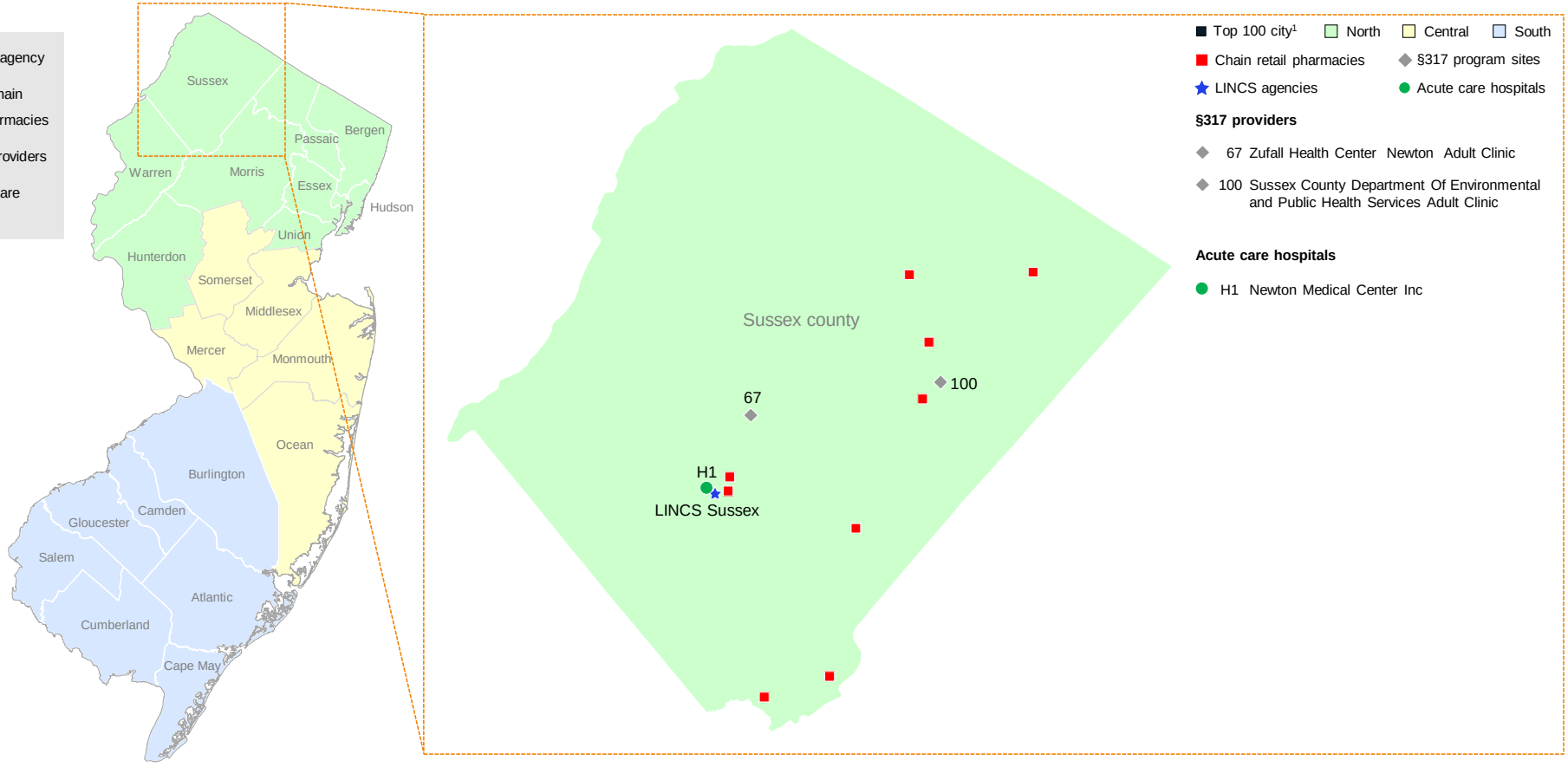
9 sites per 100,000 population

1 LINCS agency

9 large chain retail pharmacies

2 §317 providers

1 acute care hospital



1. By population per US Census

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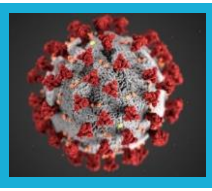


J.1.h. Potential vaccination sites in Union County (Northern region)

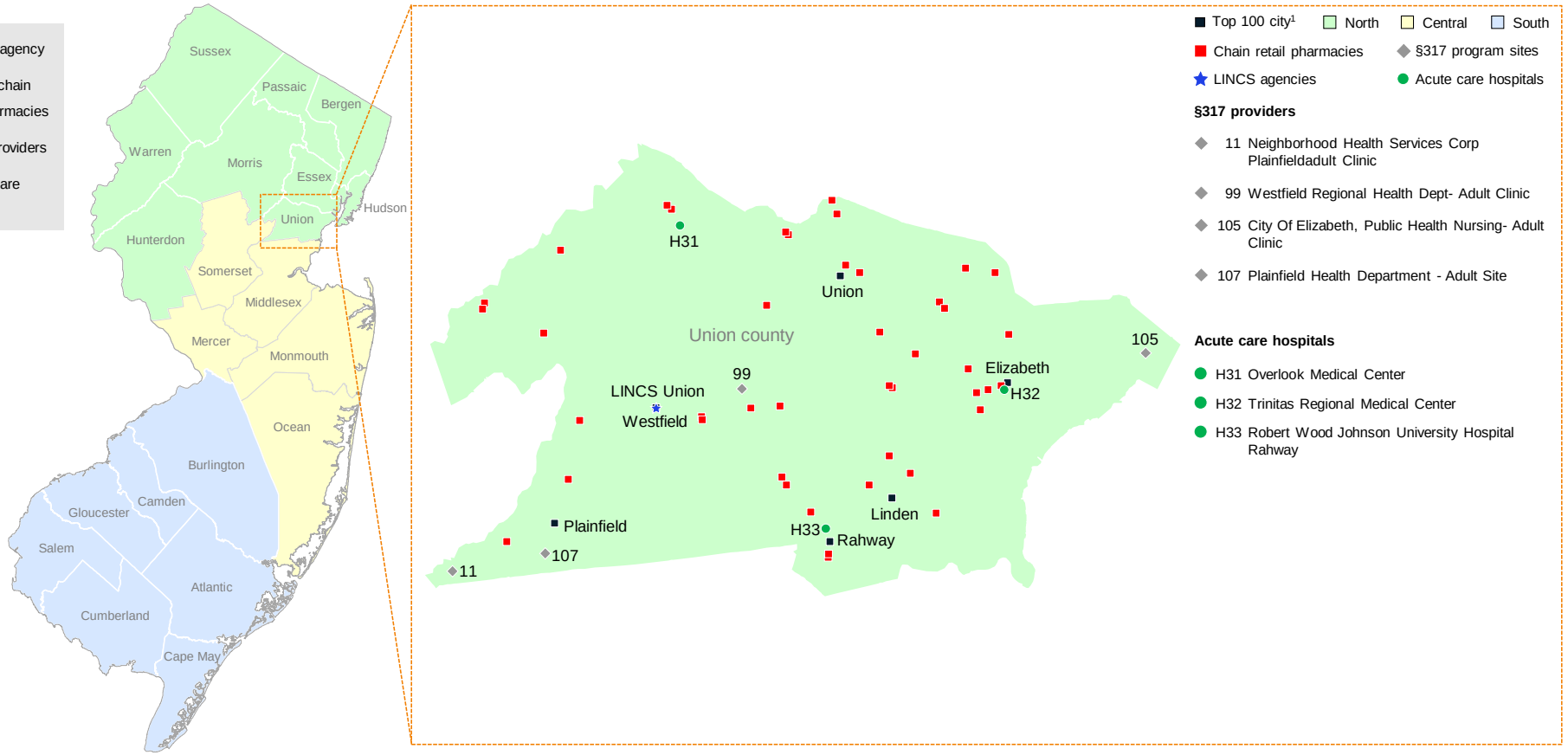
9 sites per 100,000 population

1 LINCS agency

43 large chain retail pharmacies

4 §317 providers

3 acute care hospitals



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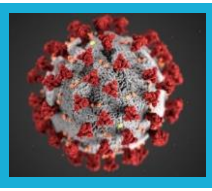


J.1.i. Potential vaccination sites in Warren County (Northern region)

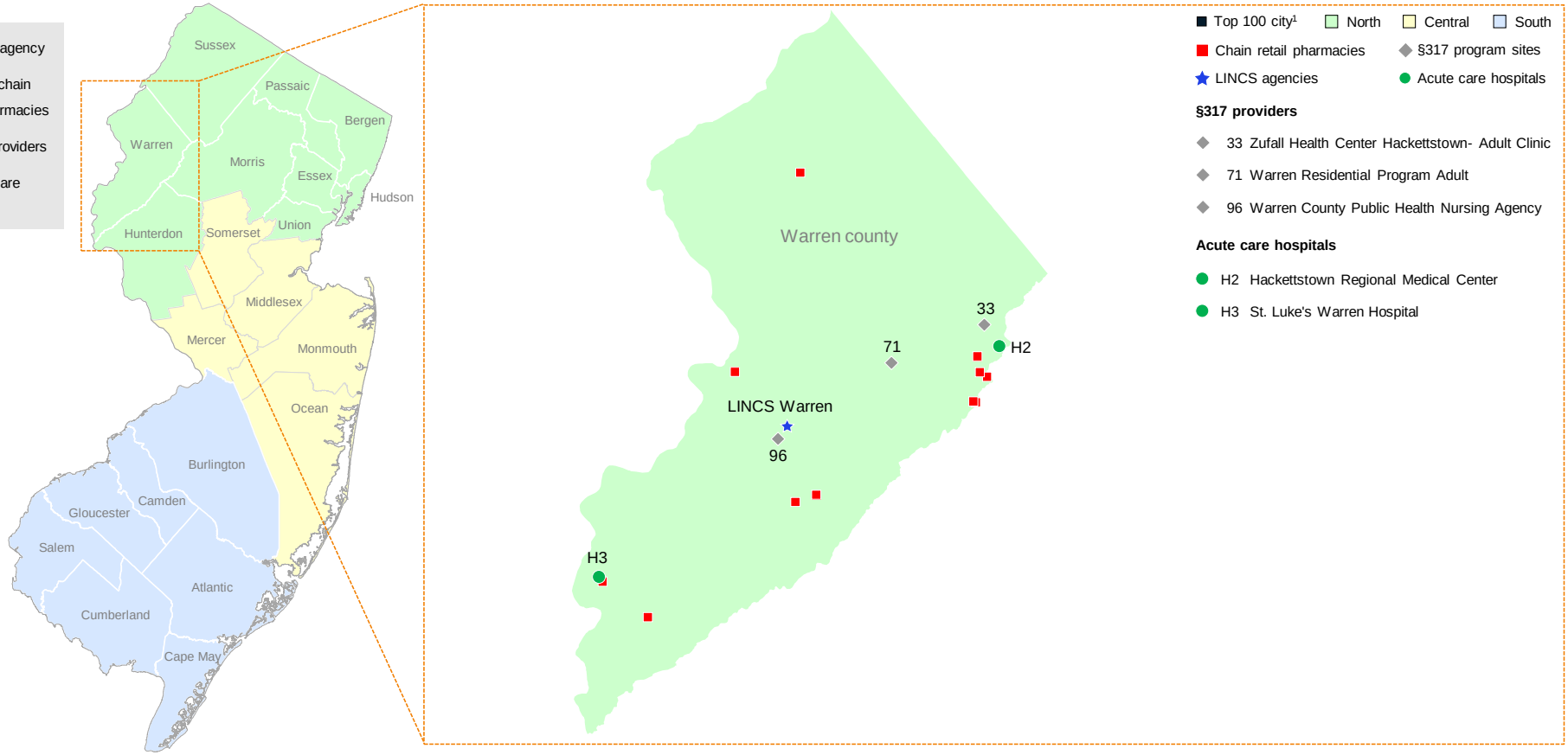
16 sites per 100,000 population

1 LINCS agency

11 large chain retail pharmacies

3 §317 providers

2 acute care hospitals



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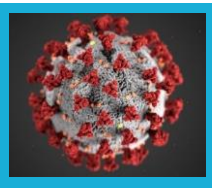


J.2.a. Potential vaccination sites in Somerset County (Central region)

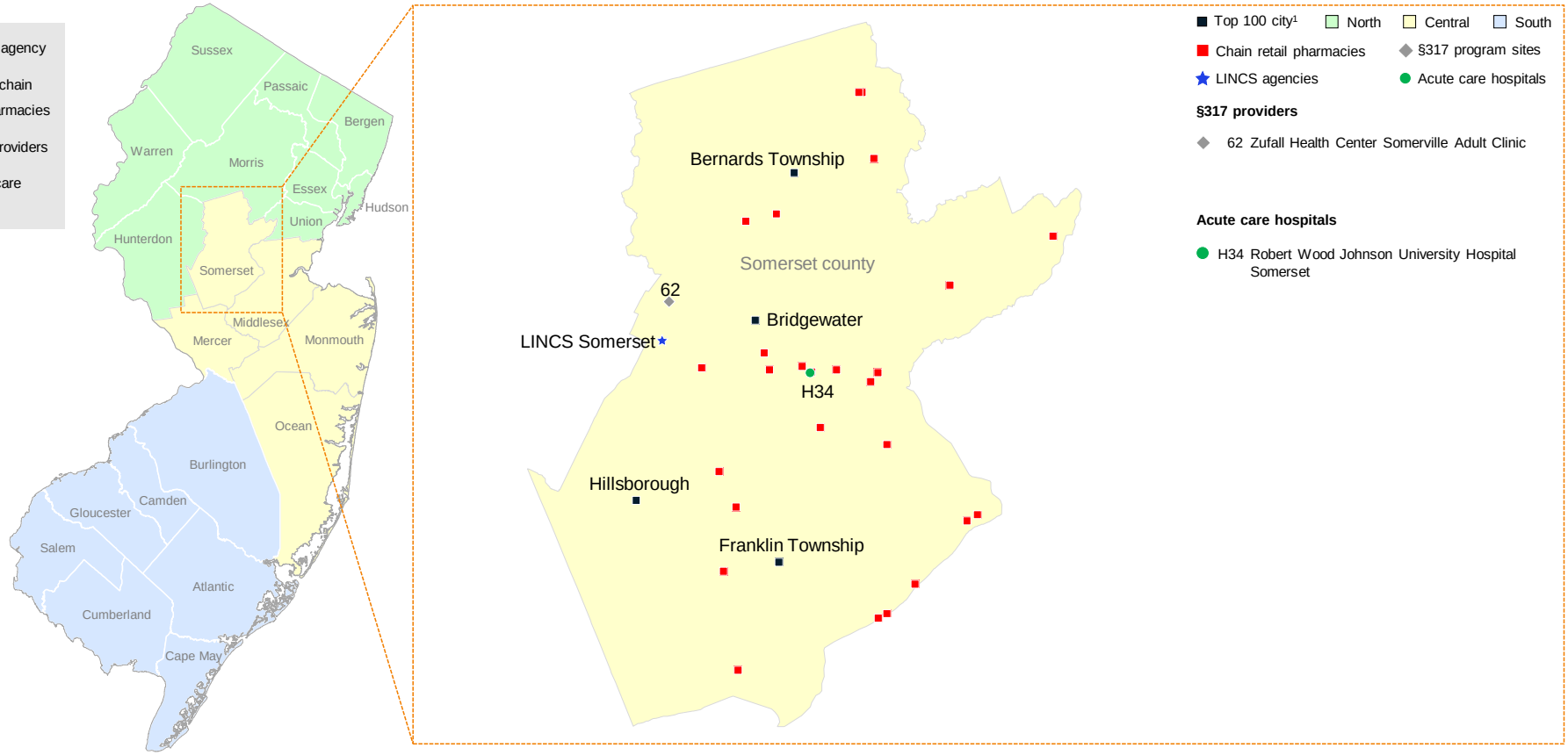
9 sites per 100,000 population

1 LINCS agency

26 large chain retail pharmacies

1 §317 providers

1 acute care hospital



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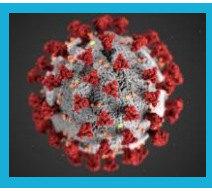


J.2.b. Potential vaccination sites in Middlesex County (Central region)

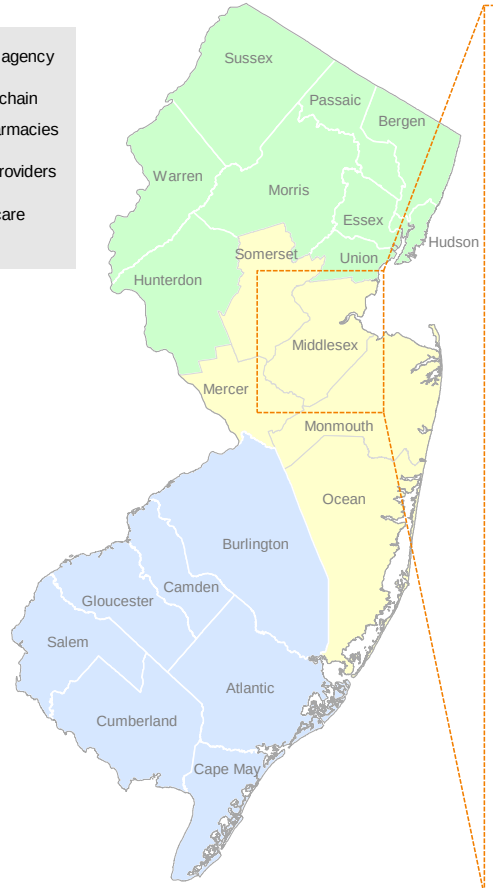
8 sites per 100,000 population

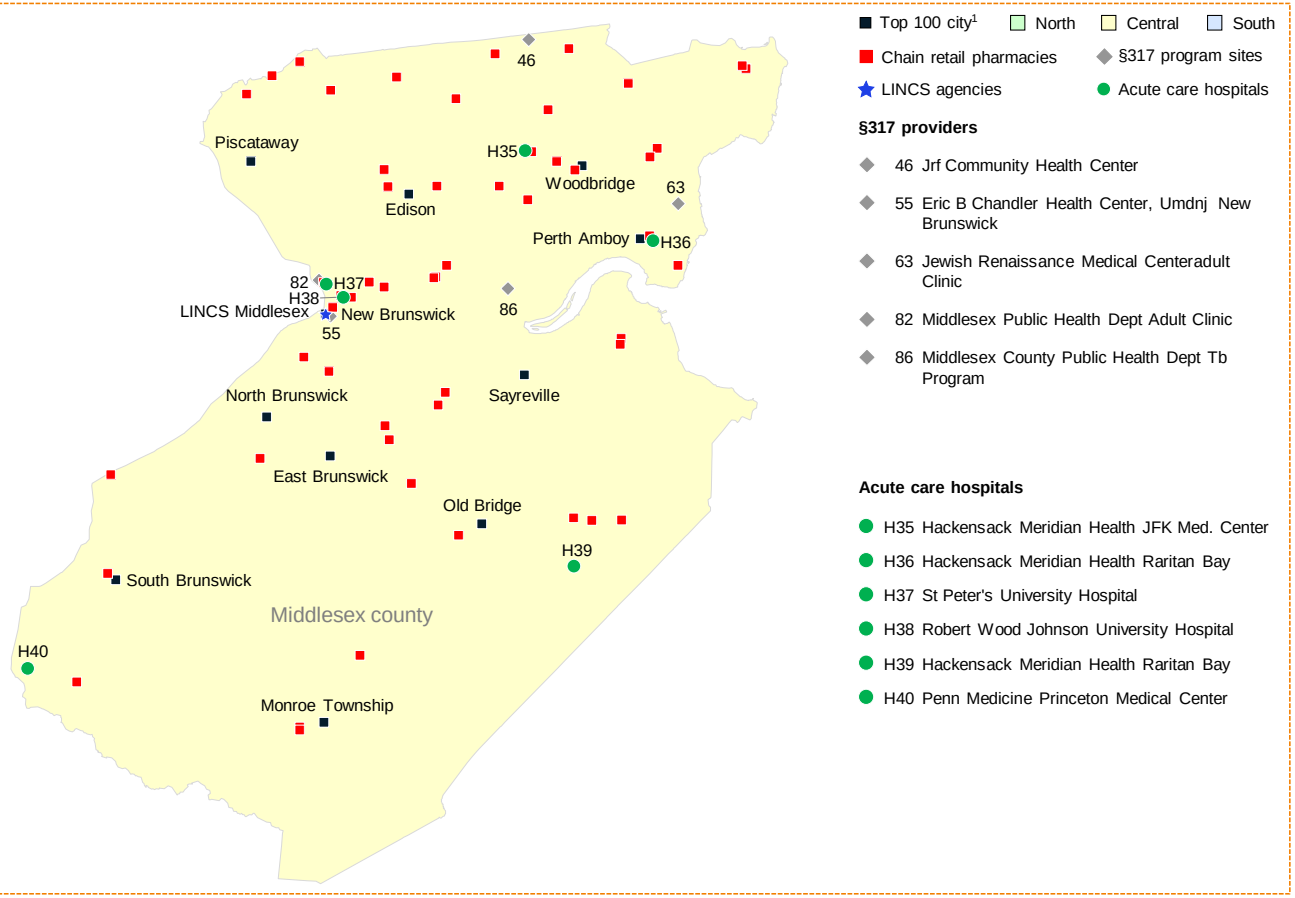
1 LINCS agency

53 large chain retail pharmacies

5 §317 providers

6 acute care hospitals





Top 100 city[1] | North | Central | South

Chain retail pharmacies | §317 program sites

LINCS agencies | Acute care hospitals

§317 providers

- 46 Jrf Community Health Center
- 55 Eric B Chandler Health Center, Umdnj New Brunswick
- 63 Jewish Renaissance Medical Centeradult Clinic
- 82 Middlesex Public Health Dept Adult Clinic
- 86 Middlesex County Public Health Dept Tb Program

Acute care hospitals

- H35 Hackensack Meridian Health JFK Med. Center
- H36 Hackensack Meridian Health Raritan Bay
- H37 St Peter's University Hospital
- H38 Robert Wood Johnson University Hospital
- H39 Hackensack Meridian Health Raritan Bay
- H40 Penn Medicine Princeton Medical Center

1. By population per US Census

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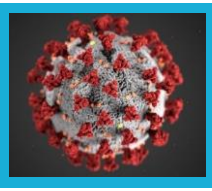


J.2.c. Potential vaccination sites in Mercer County (Central region)

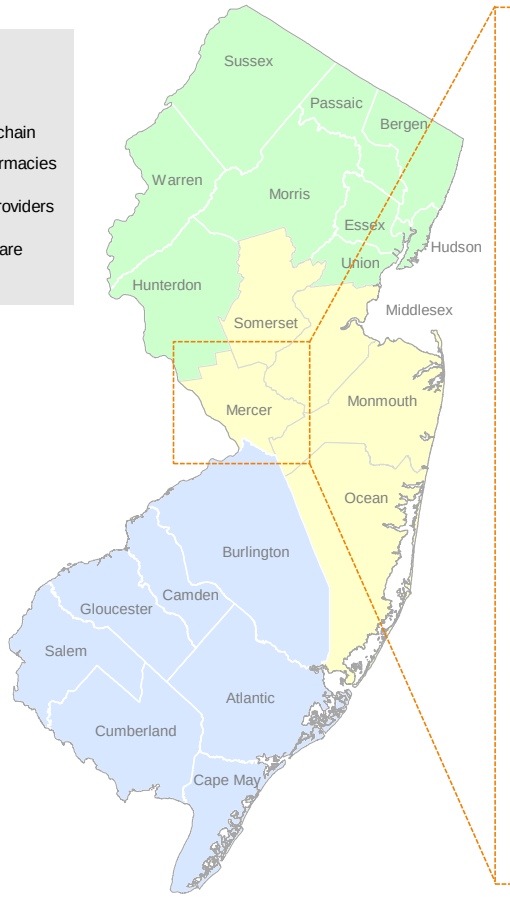
13 sites per 100,000 population

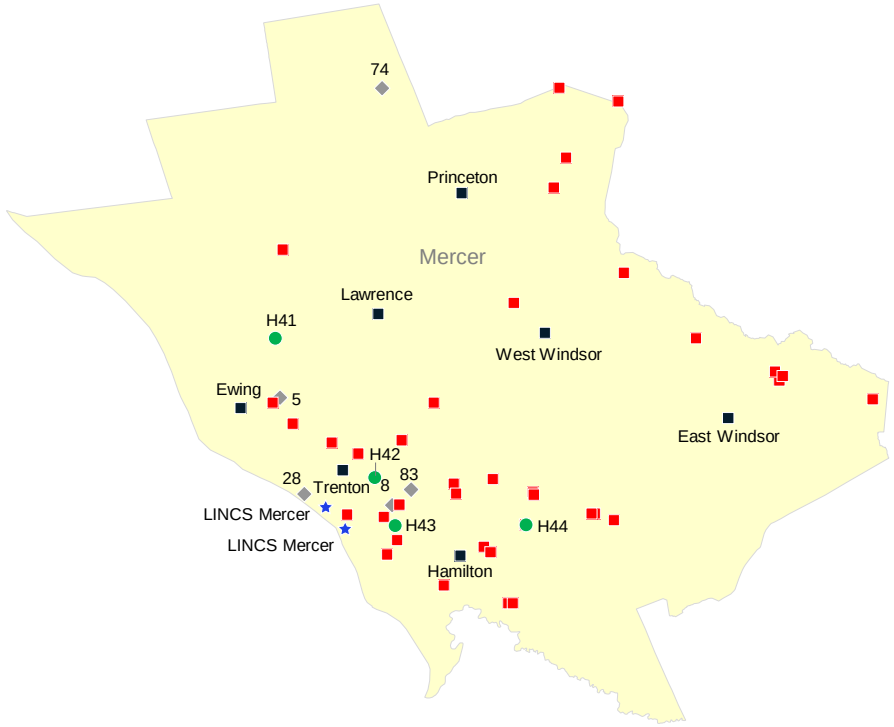
2 LINCS agencies

37 large chain retail pharmacies

5 §317 providers

4 acute care hospitals





Top 100 city[1] North Central South

Chain retail pharmacies §317 program sites

LINCS agencies Acute care hospitals

§317 providers

- 5 Henry J. Austin Health Center-Warren- Adult Clinic
- 8 Henry J. Austin Health Center - Ewing Adult Clinic
- 28 Henry J Austin Health Center Bellevue Adult Clinic
- 74 Doves Residential Adult Program
- 83 Hamilton Twp Div Of Health Adult Clinic

Acute care hospitals

- H41 Capital Health Medical Center - Hopewell
- H42 Capital Health Regional Medical Center
- H43 St Francis Medical Center, Inc.
- H44 Robert Wood Johnson University Hospital Hamilton

1. By population per US Census

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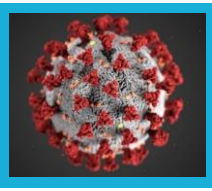


J.2.d. Potential vaccination sites in Monmouth County (Central region)

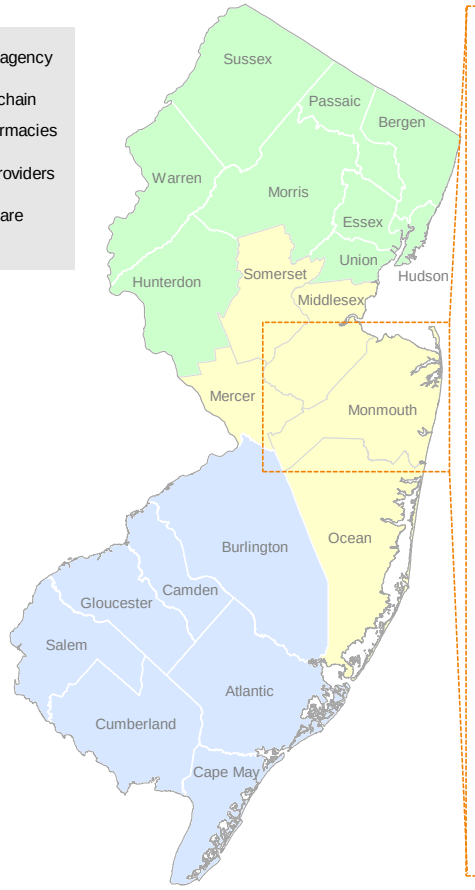
12 sites per 100,000 population

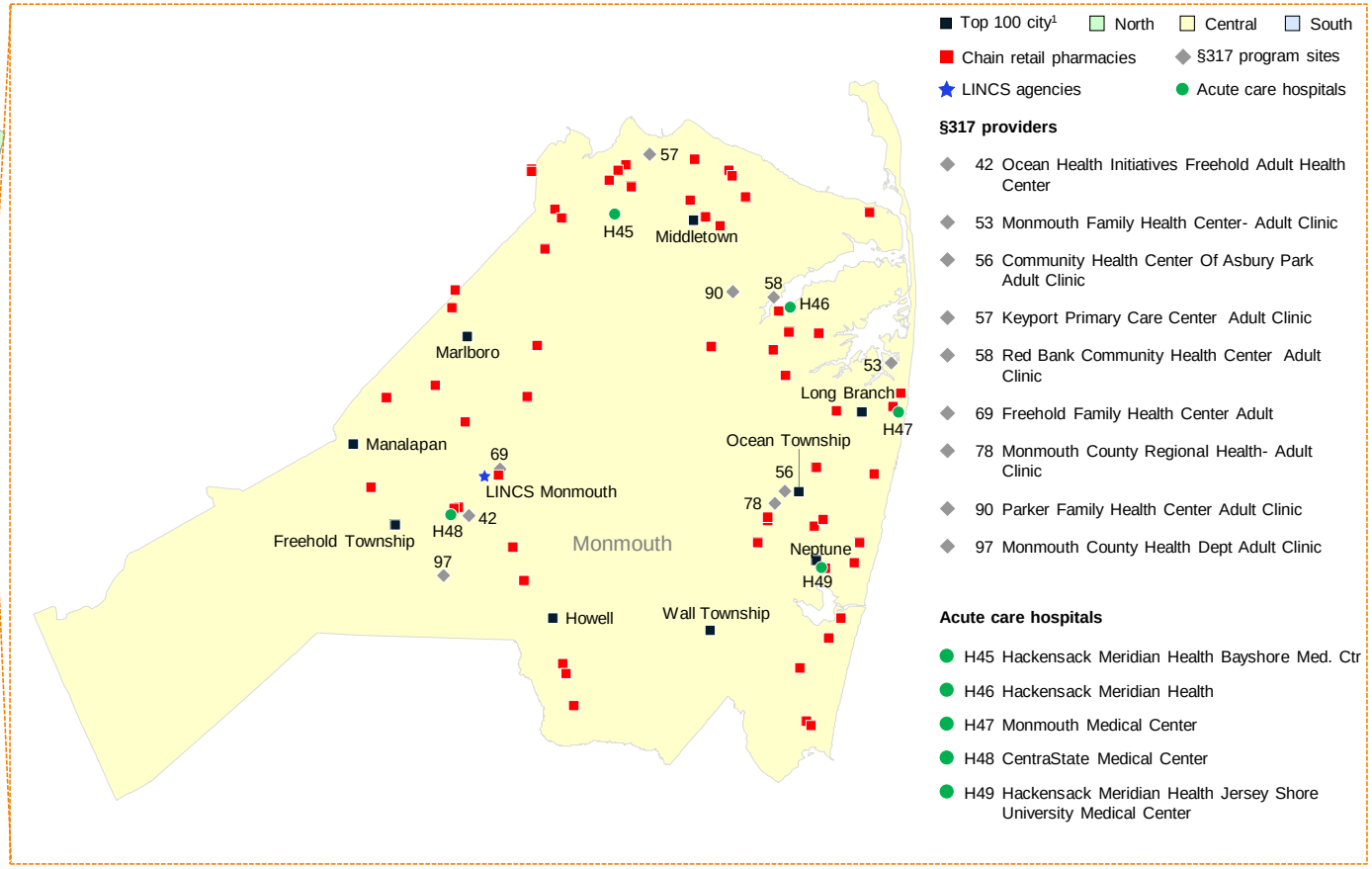
1 LINCS agency

58 large chain retail pharmacies

9 §317 providers

5 acute care hospitals





Top 100 city[1] | North | Central | South

Chain retail pharmacies | §317 program sites

LINCS agencies | Acute care hospitals

§317 providers

- 42 Ocean Health Initiatives Freehold Adult Health Center
- 53 Monmouth Family Health Center- Adult Clinic
- 56 Community Health Center Of Asbury Park Adult Clinic
- 57 Keyport Primary Care Center Adult Clinic
- 58 Red Bank Community Health Center Adult Clinic
- 69 Freehold Family Health Center Adult
- 78 Monmouth County Regional Health- Adult Clinic
- 90 Parker Family Health Center Adult Clinic
- 97 Monmouth County Health Dept Adult Clinic

Acute care hospitals

- H45 Hackensack Meridian Health Bayshore Med. Ctr
- H46 Hackensack Meridian Health
- H47 Monmouth Medical Center
- H48 CentraState Medical Center
- H49 Hackensack Meridian Health Jersey Shore University Medical Center

1. By population per US Census

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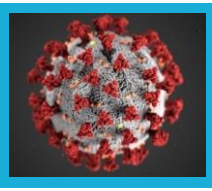


J.2.e. Potential vaccination sites in Ocean County (Central region)

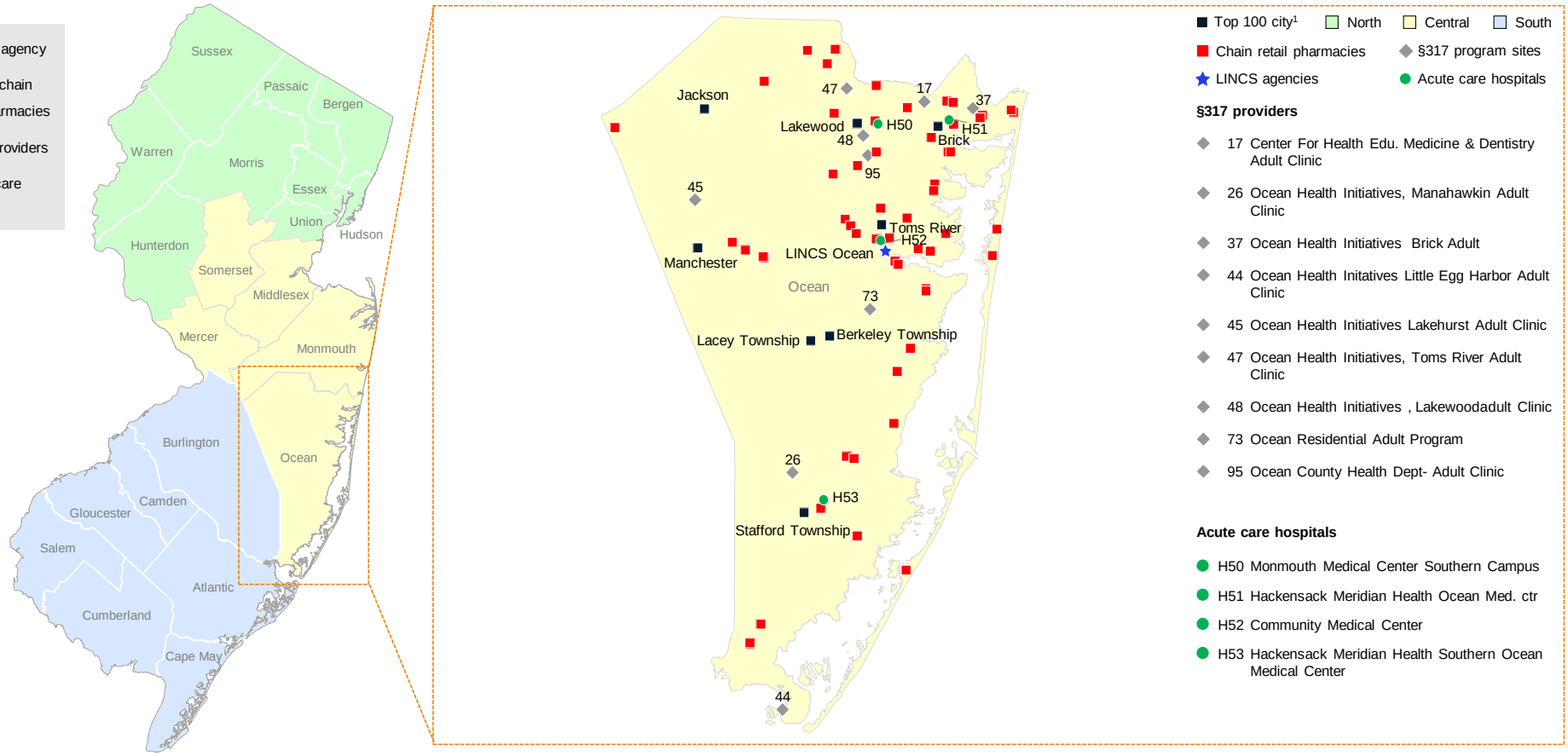
12 sites per 100,000 population

1 LINCS agency

56 large chain retail pharmacies

9 §317 providers

4 acute care hospitals



1. By population per US Census

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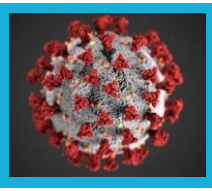


J.3.a. Potential vaccination sites in Burlington County (Southern region)

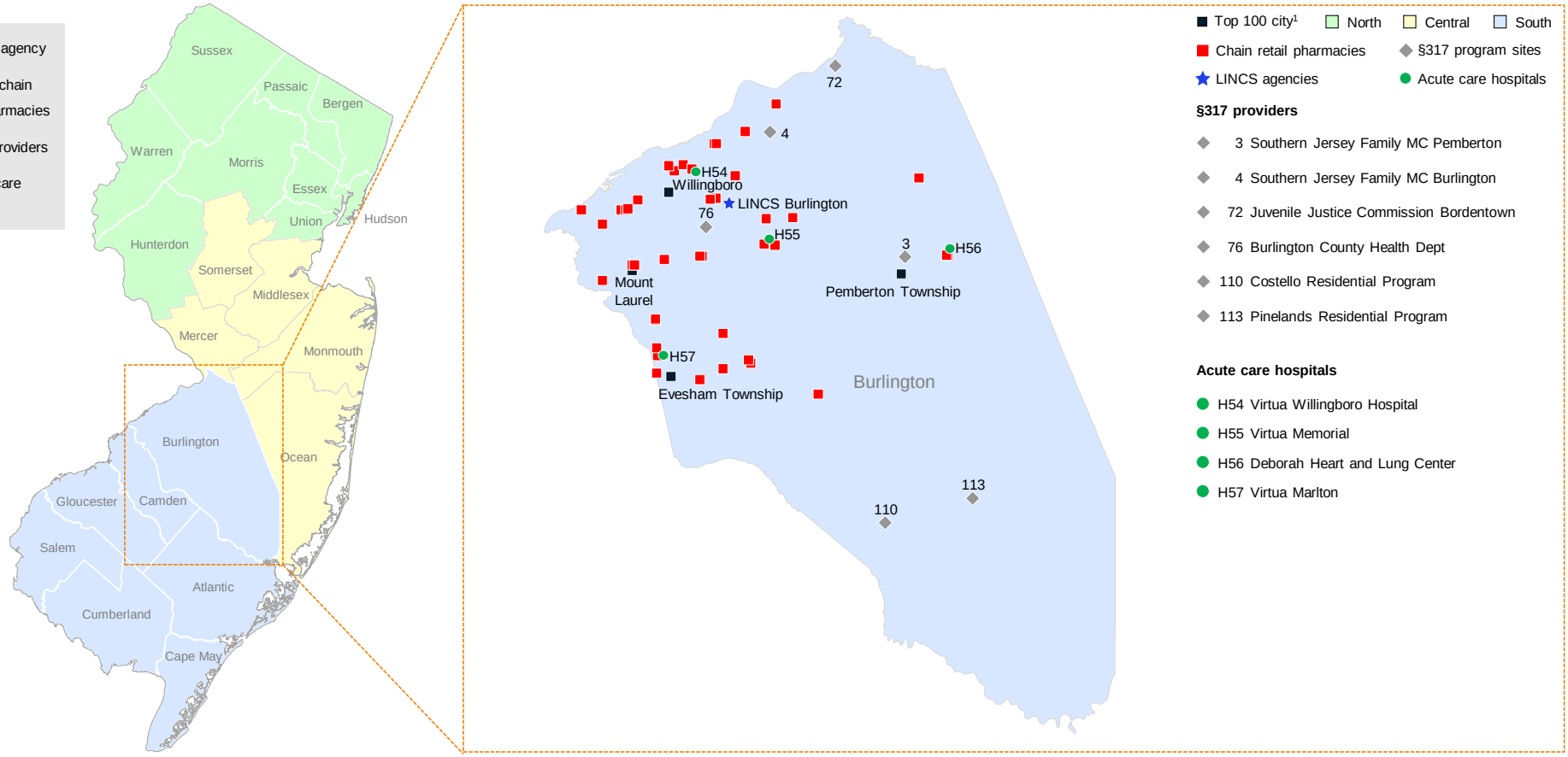
12 sites per 100,000 population

1 LINCS agency

41 large chain retail pharmacies

6 §317 providers

4 acute care hospitals



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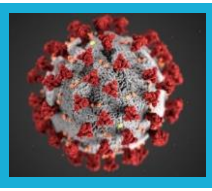
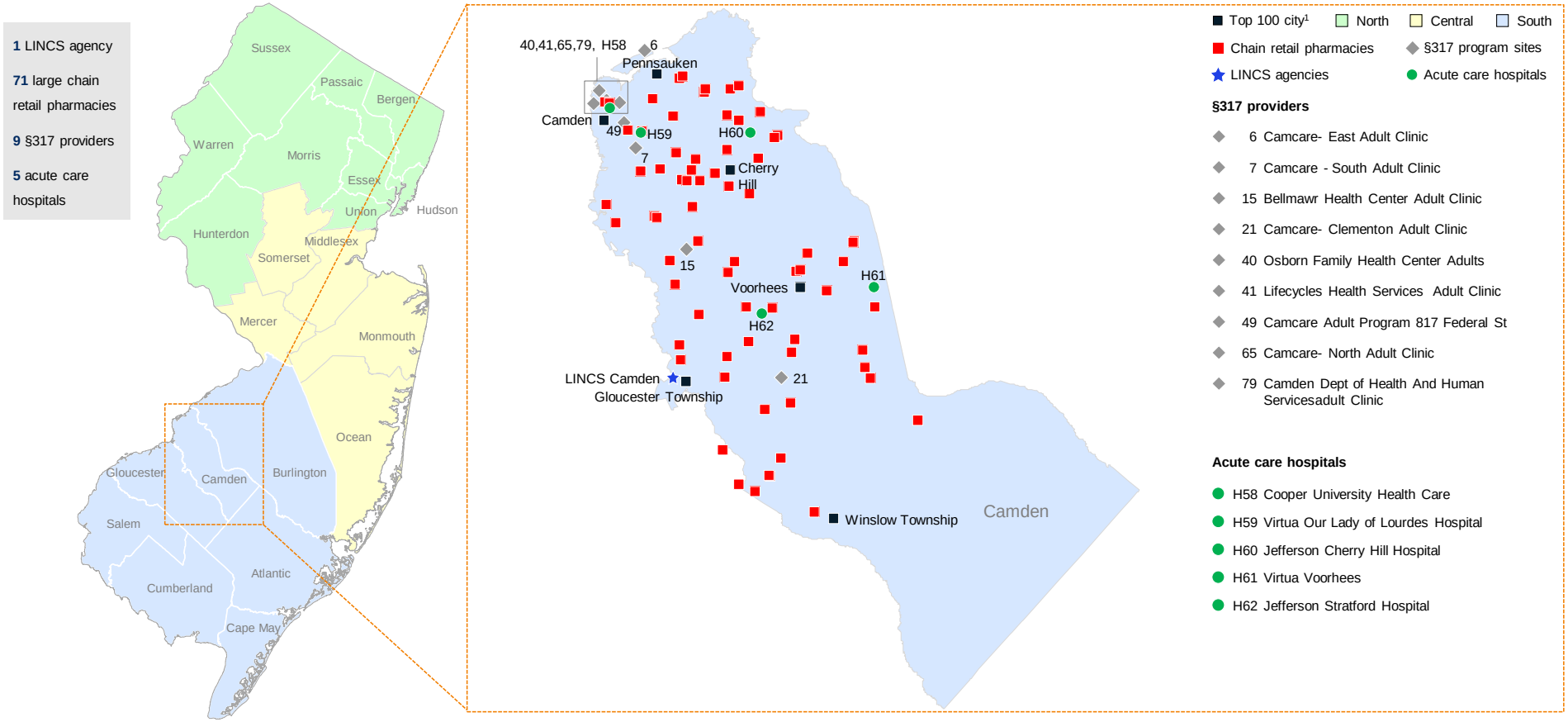


J.3.b. Potential vaccination sites in Camden County (Southern region)

17 sites per 100,000 population



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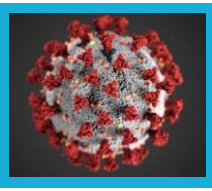


J.3.c. Potential vaccination sites in Gloucester County (Southern region)

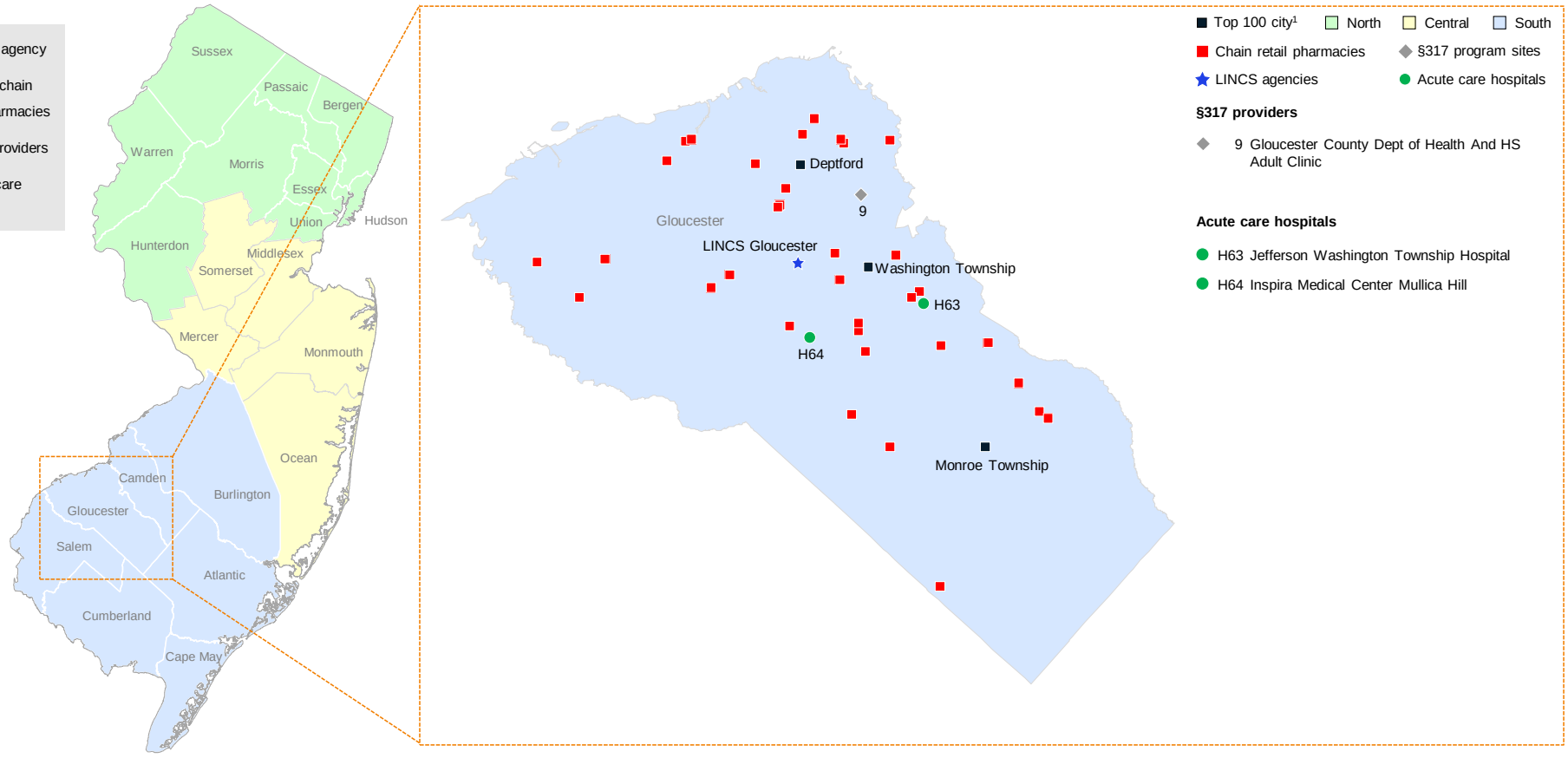
13 sites per 100,000 population

1 LINCS agency

34 large chain retail pharmacies

1 §317 providers

2 acute care hospitals



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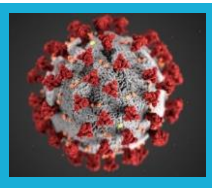
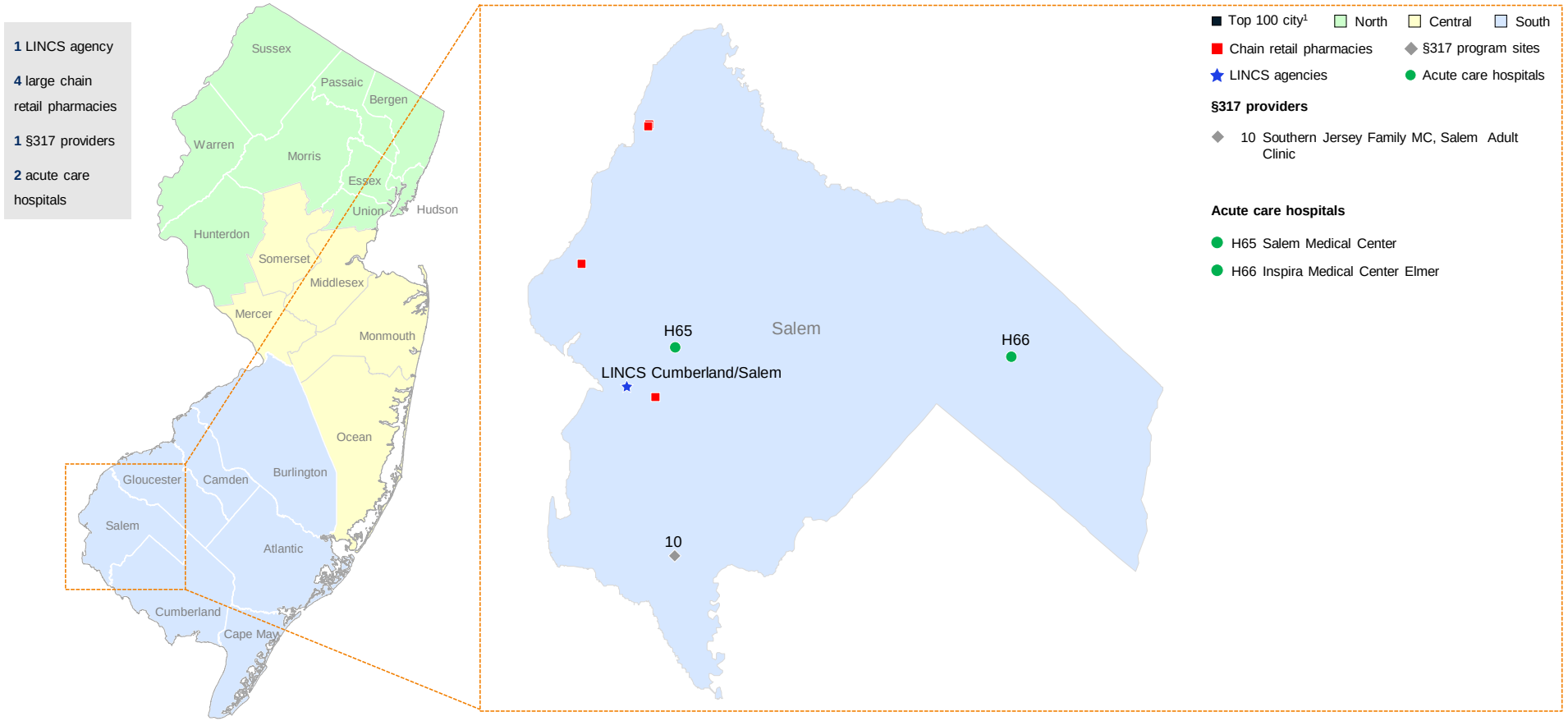


J.3.d. Potential vaccination sites in Salem County (Southern region)

13 sites per 100,000 population



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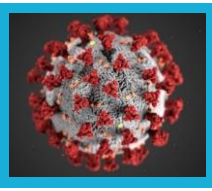
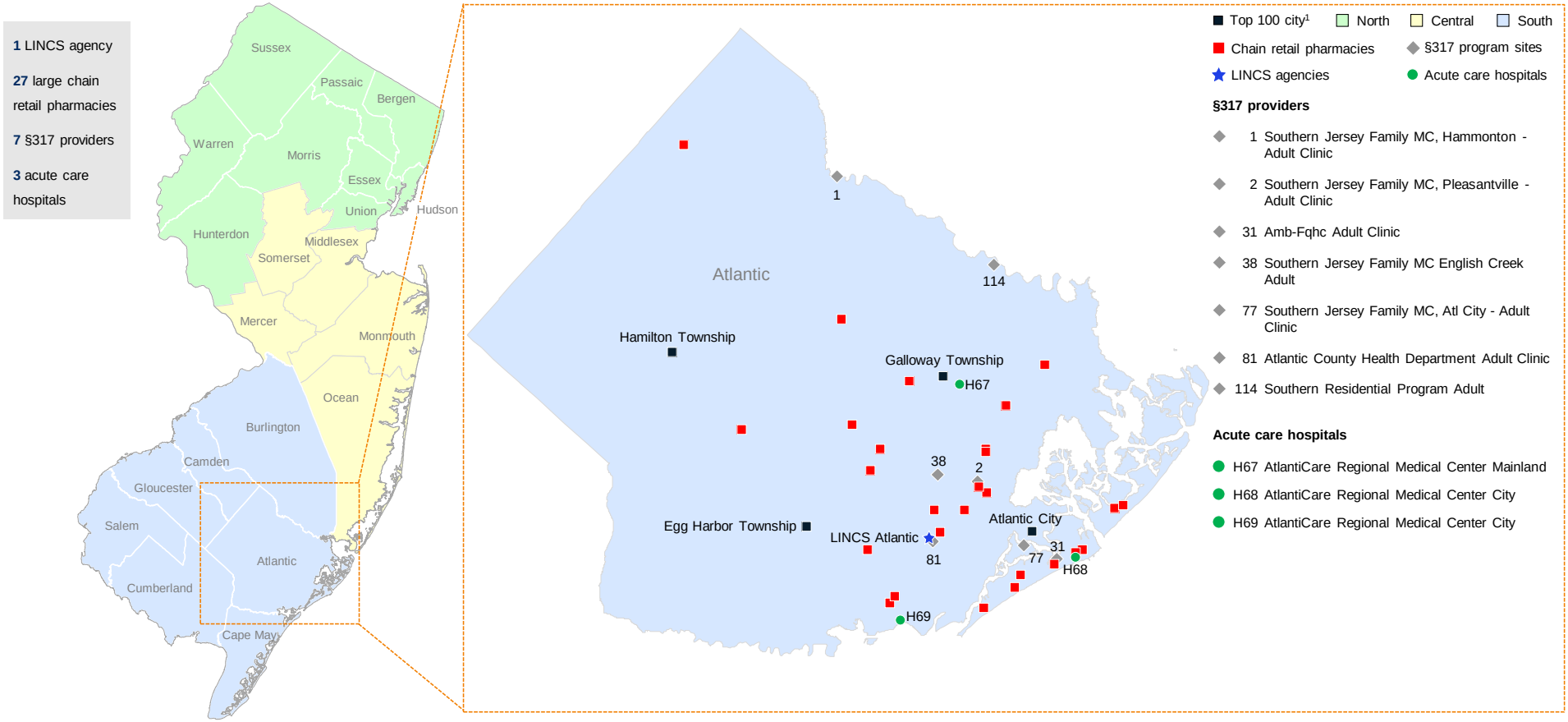


J.3.e. Potential vaccination sites in Atlantic County (Southern region)

14 sites per 100,000 population



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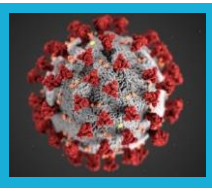
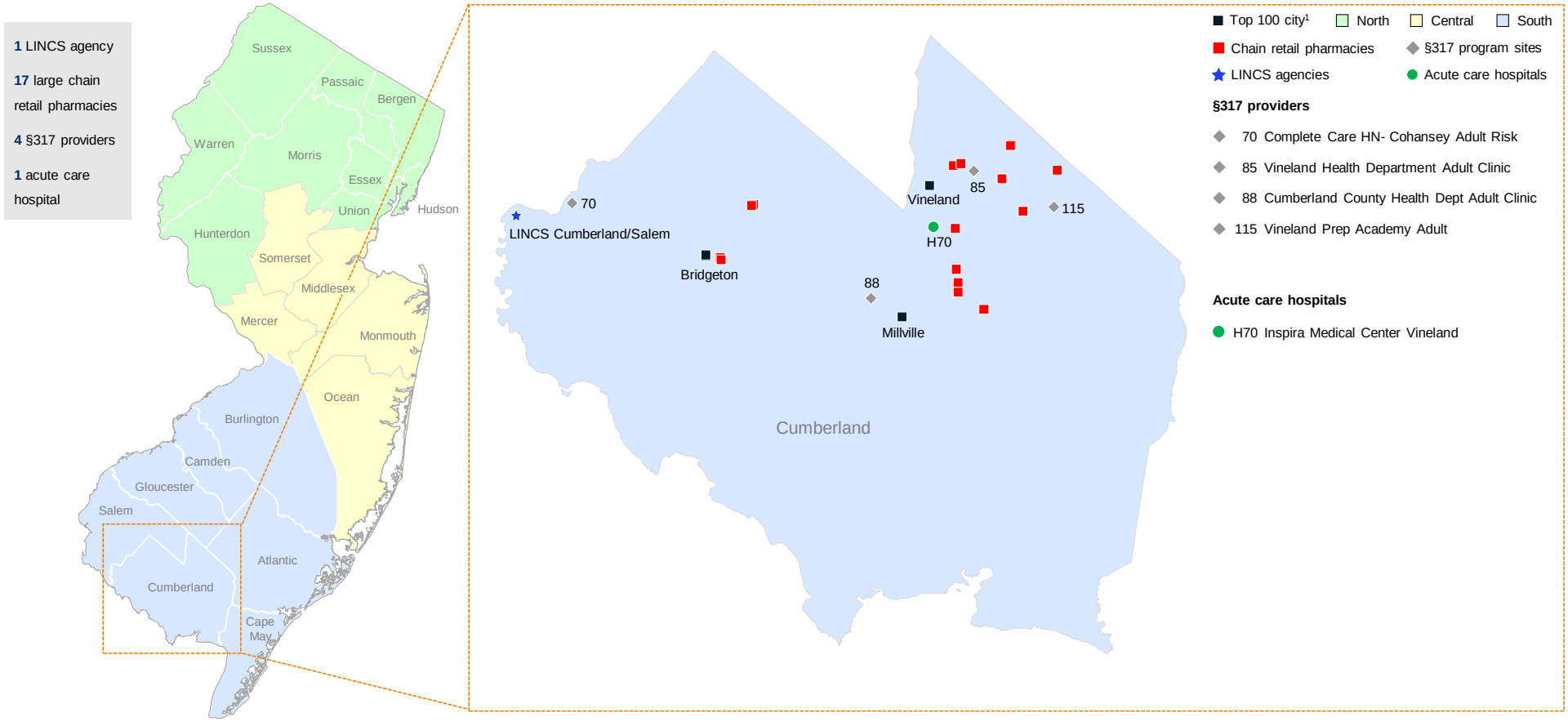


J.3.f. Potential vaccination sites in Cumberland County (Southern region)

15 sites per 100,000 population



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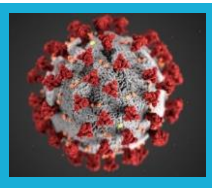
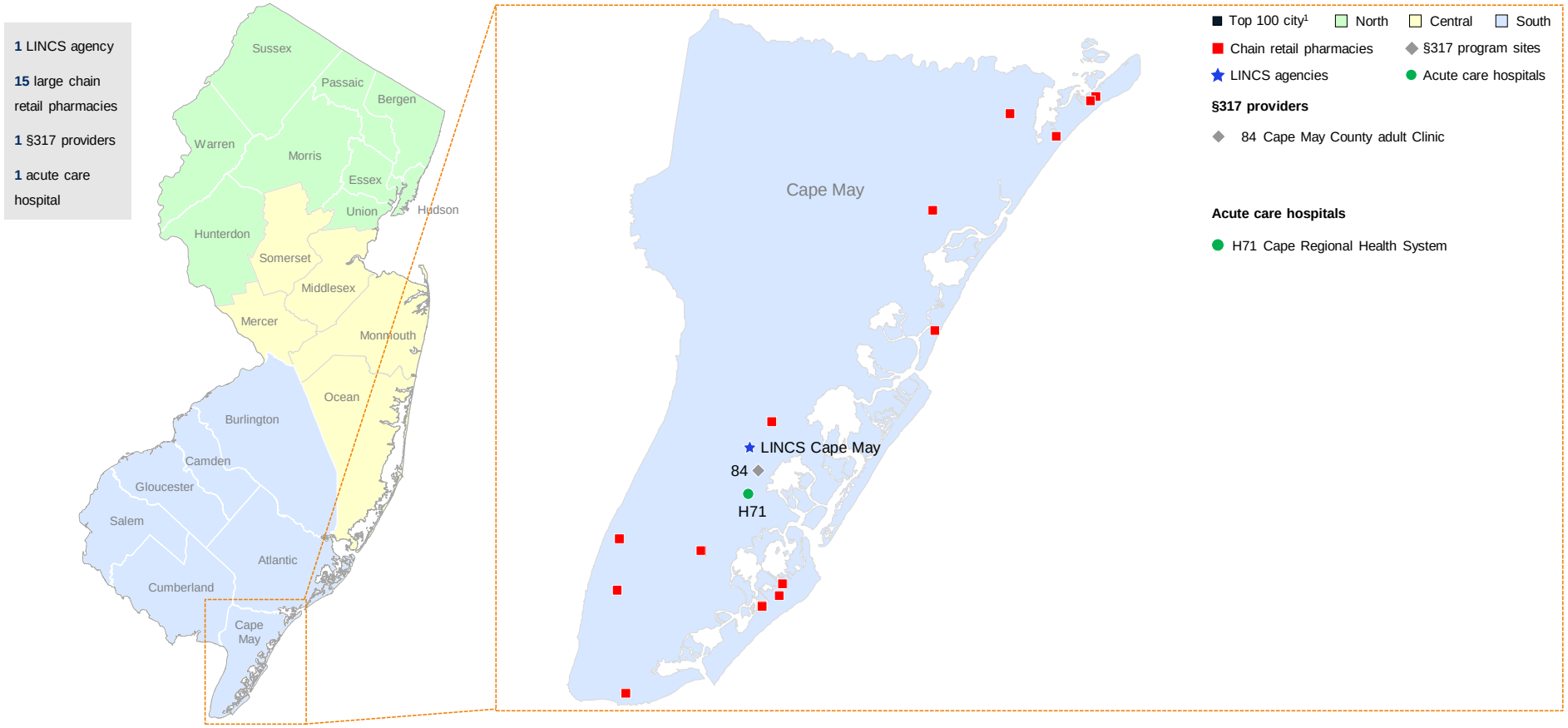


J.3.g. Potential vaccination sites in Cape May County (Southern region)

20 sites per 100,000 population



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