CENTRAL NH PUBLIC HEALTH NETWORK JURISDICTIONAL RISK ASSESSMENT

Summary of Findings

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Background Information

This report summarizes the results of a 2018-2019 Jurisdictional Risk Assessment (JRA) process undertaken by the Central NH Public Health Network (PHN).

The JRA was conducted to rate the impacts of a set of hazards to the regional health care, behavioral health, and public health systems and to identify system vulnerabilities and mitigation strategies to reduce the risks posed by these disasters. This JRA built upon the 2012-2014 Hazard Vulnerability Assessment (HVA) process and was part of a statewide process to conduct JRAs for each of the 13 PHNs, as well as the statewide Granite State Health Care Coalition (GSHCC).

The objectives of the JRA were to:

- Learn from regional partners about gaps and current preparedness efforts;
- Gather partner input to guide regional planning and mitigation activities for the next five years;
- Increase preparedness of partners to respond to emergencies; and
- Meet federal and state requirements to complete a JRA every five years.

Jurisdictional Risk Assessment Methodology

Overview of the JRA Process

The NH Department of Health and Human Services (DHHS) and the 13 PHNs worked with the Community Health Institute/JSI Research & Training Institute, Inc. (CHI) to develop and implement the JRA process. The overall process was based on the 2012-2014 Boston Metropolitan Statistical Area (MSA) HVA process that CHI also implemented as part of a Centers for Disease Control and Prevention (CDC)-funded pilot to design methodologies for HVAs focused on the health, public health, and behavioral health systems.

The participatory JRA engaged a broad spectrum of partners throughout all phases of the process:

- Assessment of hazard impact severity and regional preparedness;
- Identification of top concerns, areas for improvement, and potential mitigation strategies; and
- Prioritization of potential mitigation strategies and discussion of strategy implementation next steps.

Partner input was gathered through a survey and an in-person, half-day meeting. Further information on survey development and implementation, as well as the in-person meeting, is provided below.

Survey Development and Implementation

Selection of Hazards and Assessment of Hazard Impact Severity

DHHS, GSHCC, and CHI selected the hazards to be included in this JRA process, in part based on the scenarios that were included in the 2012-2014 HVA process. The hazard selection process included consideration of both hazards that are likely to occur and of less probable hazards with more severe

impacts. Finally, the hazards selected were reviewed to ensure that key public health and health care response functions (e.g., decontamination, medical surge, medical countermeasures dispensing) would be considered at least once during the hazard assessment process.

Ultimately, survey respondents were presented with six hazard scenarios. Each scenario included background information and data on the projected impact of the disaster on the state's health care, behavioral health, and public health systems. Projected impacts were presented as increases or decreases in service demand or availability compared to a typical day and were based on actual impacts seen in similar disasters, data derived from models, or assumptions made in the National Planning Scenarios.

Hazard Scenarios

- Blizzard
- Chemical Spill
- Cyber Attack
- Earthquake
- Hurricane
- Influenza Pandemic

Following each scenario, participants were asked to rate the impact of the hazard on the public health and health care delivery systems using a 5-point scale ranging from Very Low (1) to Very High (5). In addition, respondents were asked to identify their top concerns regarding each hazard scenario.

Assessment of Regional Preparedness

Survey respondents were asked to rate regional preparedness by responding to 35 questions based on the Office of the Assistant Secretary for Preparedness and Response's (ASPR's) Health Care Preparedness and Response Capabilities and CDC's Public Health Preparedness Capabilities.

Preparedness Categories

- Preparedness & Planning
- Emergency Operations, Information Sharing & Public Information
- Volunteer Management & Responder Safety and Health
- Surge Management
- Countermeasures

These questions were organized into 5 preparedness categories, shown on the left. Each respondent was asked to respond to questions in at least 2 of the categories that aligned best with their areas of expertise. For each question, participants were asked to rate the regional system's preparedness using a 5-point scale ranging from No Capacity (1) to Full Capacity (5). Additionally, for each preparedness category, respondents were asked to identify the most significant areas for improvement related to that category.

Identification of Potential Mitigation Strategies

At its conclusion, the survey asked respondents to suggest steps for improving regional preparedness and response capacity. CHI developed a list of potential mitigation strategies based on responses to this and other open-ended survey questions, and presented the list to the PHN's Public Health Emergency Preparedness (PHEP) Coordinator for review. A final list of mitigation strategies was developed, considering mitigation efforts currently underway or already completed, as well as the PHN's potential roles in implementation and strategy feasibility.

Partner Meeting

Regional partners were invited to a half-day meeting to review and validate the survey results, as well as prioritize potential mitigation strategies for implementation. At this meeting, the hazard impact

ratings and preparedness ratings were presented to meeting attendees, who were given the opportunity to discuss and reflect on the survey results.

Following this discussion, the list of potential mitigation strategies was presented. When available, a summary of background research and best practices was presented prior to discussion of each potential mitigation strategy among attendees.

Next, meeting attendees were asked to vote for the mitigation strategies that they felt would be the most impactful and feasible to implement. Each participant was able to vote for two strategies. After voting, meeting attendees participated in a facilitated discussion regarding the implementation of the selected strategies.

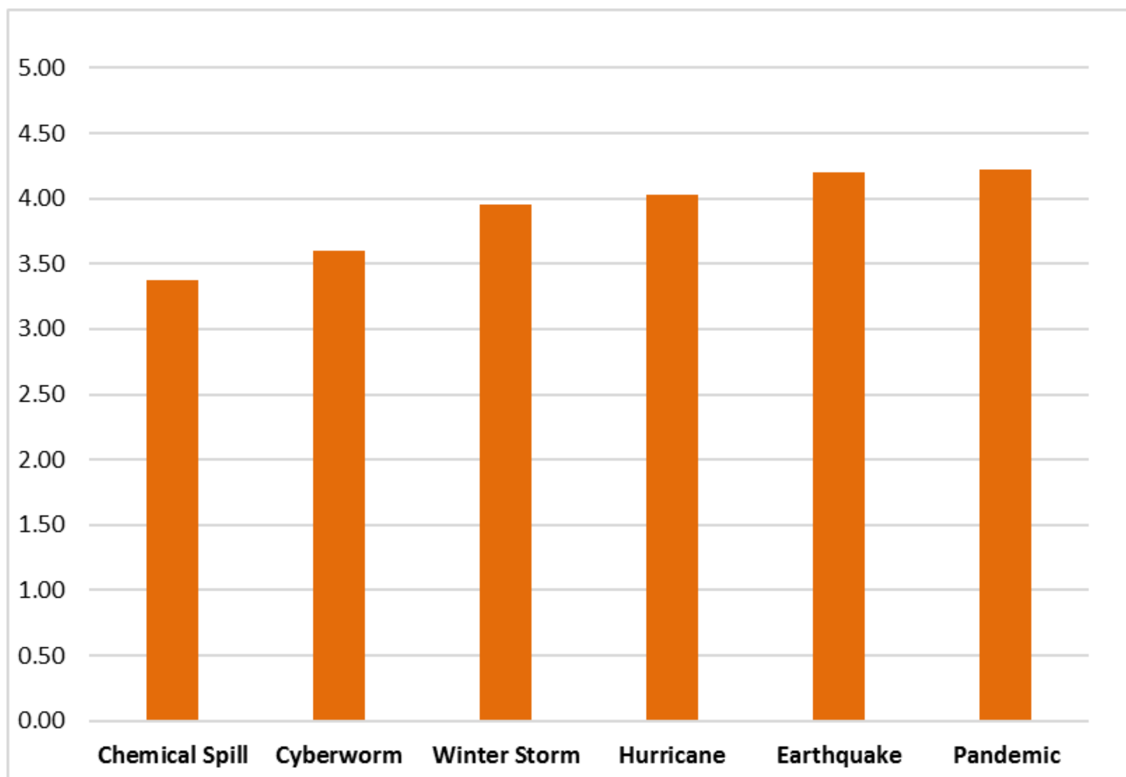
Jurisdictional Risk Assessment Results

Forty-three survey responses were received and 21 partners attended the meeting. The following section summarizes the results of the overall process. A full list of JRA participants is included as Attachment 1.

Hazard Impact Severity Ratings

Figure 1 shows the average hazard rating given by survey respondents for each scenario using a 5-point scale ranging from Very Low (1) to Very High (5).

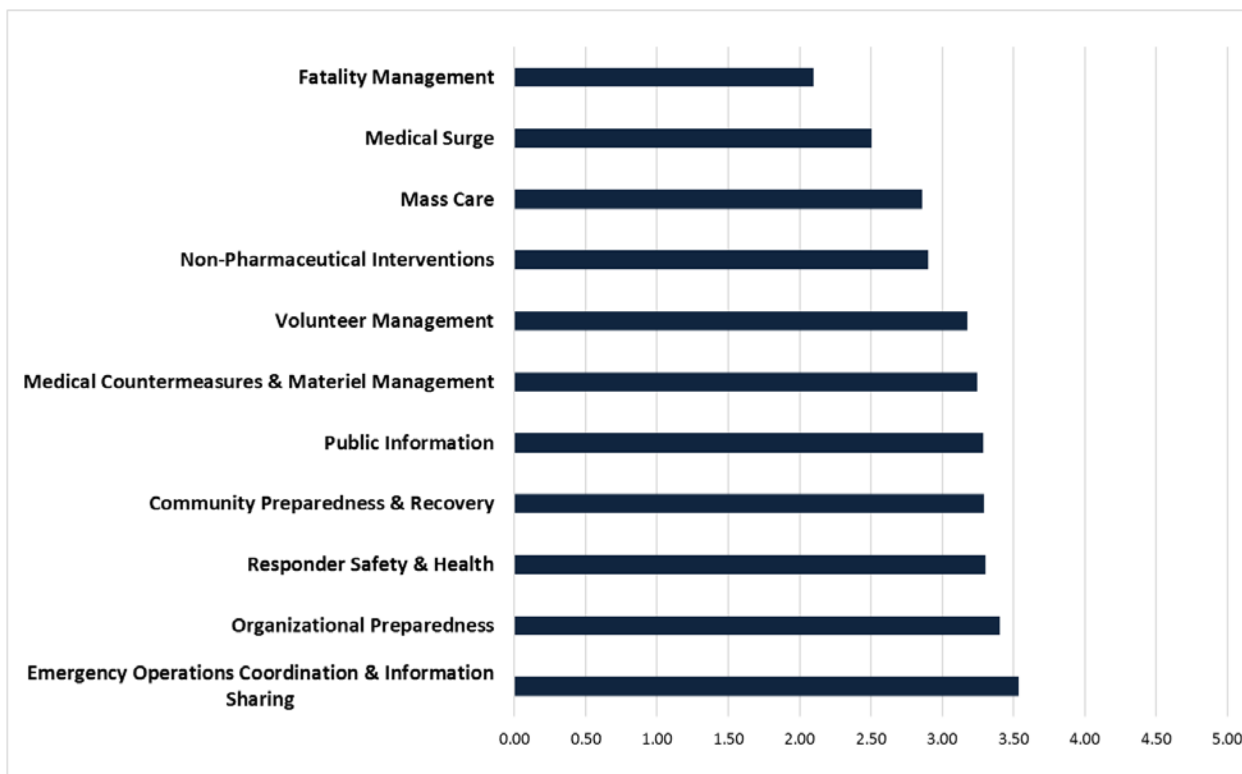
Figure 1. Impact of Each Hazard Scenario on the Health Care, Behavioral Health, and Public Health Systems



Preparedness Ratings

Figure 2 shows the average preparedness rating given by survey respondents for each preparedness category. Note that each category was made up of 3-10 questions, each of which were rated on a 5-point scale ranging from No Capacity (1) to Full Capacity (5). Ratings for each individual question can be found in Attachment 2.

Figure 2. Preparedness Ratings, by Category



Identification and Prioritization of Potential Mitigation Strategies

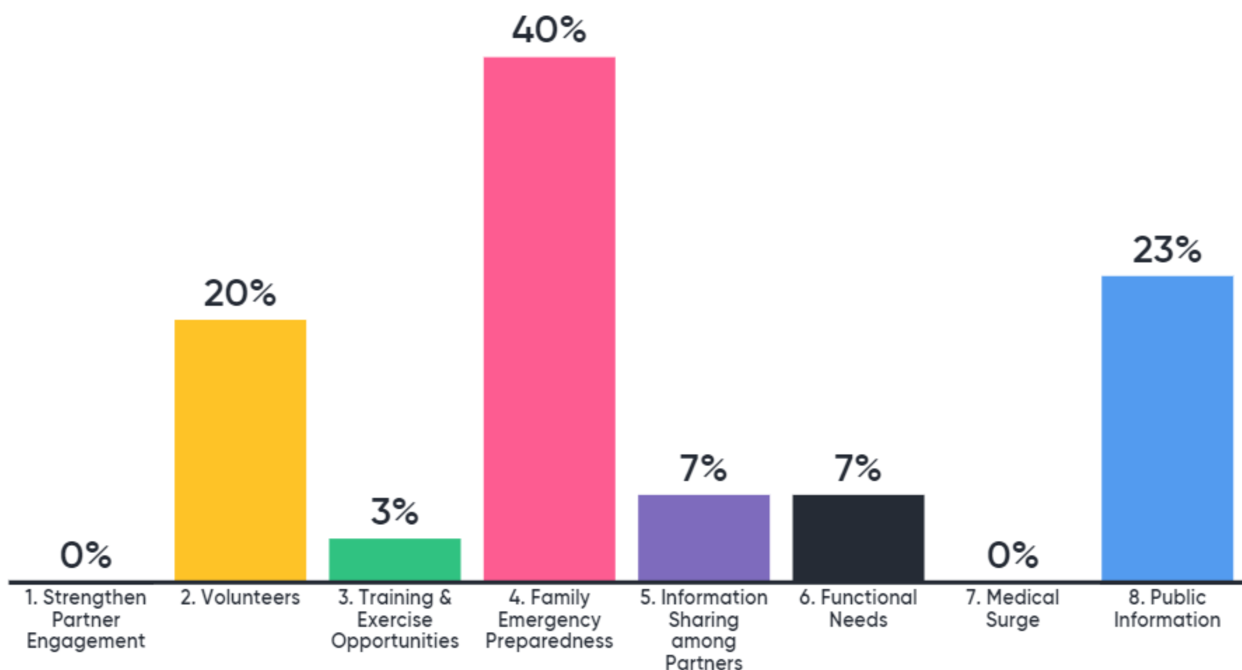
As noted above, CHI worked with the PHN PHEP Coordinator to develop a list of potential mitigation strategies for prioritization. Based on this process, the 8 strategies considered for prioritization by meeting participants were:

1. Strengthen engagement of regional partners in the PHN.
    - Engage additional partners.
    - Promote the benefits of involvement in PHN activities to organizations, including senior leadership.
    - Ensure partner are aware of the capabilities and roles of the PHN and other partners.
2. Recruit, train, and retain volunteers.
3. Provide training and exercise opportunities to partners.

4. Develop a regional strategy to promote personal preparedness.
5. Identify and address barriers to sharing information among regional partners during an emergency response.
6. Strengthen regional capacity to meet the needs of individuals with functional needs.
7. Strengthen regional preparedness to support health care facilities in the event of medical surge.
8. Assess and strengthen regional capacity to provide information to the public.

In order to facilitate the prioritization process, a summary of each potential mitigation strategy, along with related background and best practice research, was presented to meeting attendees. CHI then facilitated a discussion with regional partners regarding potential implementation of these strategies. A summary of the discussion regarding each of the strategies is included in Attachment 3. After each strategy was discussed, attendees were given the opportunity to suggest mitigation strategies for consideration that may have been excluded by survey respondents. Voting results are included in Figure 3.

Figure 3. Mitigation Strategy Prioritization Voting Results



Implementation of Selected Mitigation Strategies

Based on these voting results, the top two strategies were selected for implementation:

1. Develop a regional strategy to promote personal preparedness.
2. Assess and strengthen regional capacity to provide information to the public.

Meeting participants discussed current activities related to the selected strategy and next steps that would be needed in order to implement the selected strategies. A summary of the discussion regarding each of the selected strategies is included in Attachment 3.

Next Steps

Central NH PHN will continue to discuss next steps for implementation of the selected mitigation strategies with regional partners to develop a more detailed workplan that will be used to support strategy implementation. In addition, findings of the JRAs being conducted with the 13 PHNs and the GSHCC will be summarized at the state level and reviewed by DHHS to identify potential statewide improvements or opportunities to align regional efforts.

Attachment 1: JRA Participants

ORGANIZATION	PARTICIPATION	
	SURVEY	MEETING
BeBop Labs		✓
Campton-Thornton Fire Rescue	✓	
Central NH Community Emergency Response Team (CERT)	✓	✓
Central NH Medical Reserve Corps (MRC)	✓	✓
Central NH Multi-Agency Coordinating Entity (MACE)	✓	✓
Communities for Alcohol and Drug-Free Youth (CADY)		✓
Community Action Program, Belknap-Merrimack Counties, Inc.	✓	✓
Franklin Visiting Nurse Association & Hospice	✓	
Granite State Health Care Coalition/Foundation for Healthy Communities	✓	✓
Lakes Region Mental Health Center	✓	✓
Mid-State Health Center	✓	✓
New Hampshire Department of Health and Human Services	✓	✓
New Hampshire Veterans Home	✓	
New Hampton Fire Department	✓	
Newfound Area Nursing Association		✓
Pemi-Baker Community Health	✓	✓
Pemi-Baker Home Health Agency	✓	
Plymouth State University	✓	✓
Speare Memorial Hospital	✓	
Tapply-Thompson Community Center	✓	
Town of Alexandria Police Department	✓	
Town of Ashland Fire Department		✓
Town of Bristol	✓	✓
Town of Holderness	✓	

ORGANIZATION	PARTICIPATION	
	SURVEY	MEETING
Town of Lincoln Fire Department	✓	
Whole Village Family Resource Center		✓

Attachment 2: Preparedness Rating Questions

Category	Average
Fatality Management	
Assisting with the safe recovery, receipt, identification, transportation, storage, and disposal of human remains, including management of contagious, chemically, or radiologically contaminated remains.	1.60
Providing support to families of the deceased and survivors, including: -Establishing Family Assistance Centers -Family reunification -Collecting and disseminating antemortem data -Providing behavioral health services to survivors and family members of the deceased.	2.60
Medical Surge	
Providing specialized care during a medical surge response, including pediatric, burn, and trauma specialized services, and ensuring those who can benefit from specialty services receive priority for transfer.	2.00
Responding to a chemical or radiation emergency, including decontamination of individuals.	2.00
Assessing and addressing the acute behavioral health needs of affected communities, including children.	2.63
Activating alternate care facilities to provide care when demand overwhelms a jurisdiction's health care delivery system for a prolonged period.	2.67
Responding to infectious disease outbreaks, including screening of patients for signs, symptoms, and relevant travel and exposure history and rapidly isolate, when needed.	2.67
Managing surge through coordination of patient placement and tracking across the health care system (e.g., hospitals, home care, skilled nursing facilities, long-term care facilities).	2.71
Ensuring continued access of the public to vital health care, behavioral health, and public health services throughout response and recovery.	2.86
Mass Care	
Addressing the public health, medical, and behavioral health needs of those in public emergency shelters, including those with special medical and functional needs.	2.86
Non-Pharmaceutical Interventions	
Implementing voluntary and mandatory non-pharmaceutical interventions, including cancellation of public gatherings, travel and movement restrictions, and isolation and quarantine.	2.90
Volunteer Management	
Managing spontaneous volunteers.	3.00
Recruiting and training medical and non-medical volunteers.	3.08
Utilizing redundant communications systems to notify and activate volunteers.	3.45
Medical Countermeasures & Materiel Management	
Supporting dispensing of medical countermeasures to the target population through open and closed PODs.	3.00
Developing a plan to serve as a closed Point of Dispensing (POD) to allow for organized and timely receipt and distribution of medication or vaccines to employees, their families, and patients.	3.24
Requesting, accepting, storing, securing, and maintaining the integrity of medical materiel.	3.50
Public Information	
Working as a Joint Information System (JIS) to disseminate critical information to the media and the public, including: -Ensuring use of accessible languages and formats -Establishing avenues for public inquiries (e.g., call centers, social media) -Monitoring state, local, and New England media -Controlling the spread of rumors.	3.29
Community Preparedness & Recovery	
Addressing the unique needs of children, pregnant women, seniors, individuals with access and functional needs, etc. in planning processes.	3.14
Coordinating preparedness education with community partners, especially those serving functional needs or at-risk populations.	3.25
Offering trainings for partners to address preparedness and response gaps.	3.31
Engaging partners to ensure the jurisdiction's ability to deliver public health, medical, and behavioral health services during and after an incident, including ensuring: -Engagement of diverse partners to ensure a successful whole community response -Partners understand their role and the roles of others during a response -Partners' leadership is aware of their organizational role and engaged in preparedness activities.	3.47
Responder Safety & Health	
Identifying and communicating medical and behavioral health risks to responders, including volunteers.	3.18
Facilitating access to medical and behavioral health services for responders and volunteers during and after a response.	3.23
Identifying safety and personal protective needs of responders and volunteers, and providing medical countermeasures and personal protective equipment (PPE), as needed.	3.50
Organizational Preparedness	
Developing and maintaining an organizational continuity of operations plan.	3.28
Developing and maintaining an organizational emergency operations plan.	3.53
Emergency Operations Coordination & Information Sharing	
Utilizing redundant communication systems and platforms to exchange information with partners to provide a common operating picture.	3.43
Activating and sustaining incident command resources (e.g., human, technical, physical space, and physical assets) to address an incident.	3.64

Attachment 3: Summary of Mitigation Strategy Discussion

Prioritized Strategy #1: Develop a regional strategy to promote personal preparedness.

Eighty percent of regional partners selected this strategy as one of their top two priorities for the region.

Participants made the following observations related to this strategy:

- The public seems to know little about the practical steps they could realistically take to prepare, such as stockpiling water. This includes staff of agencies serving vulnerable populations, making it difficult for them to help clients prepare.
- Cost is often a significant barrier to preparing, especially for vulnerable populations such as those experiencing housing or food insecurity. It was noted that one-third of the regional population can be categorized as having low socioeconomic status, and that jobs that pay a livable wage are scarce in the region.
- Individuals with behavioral health concerns face unique barriers to preparing. For example, if they receive individual doses of controlled substances on a daily basis, it is impossible for them to stockpile medication.
- Individuals may be more receptive to messaging around preparedness that comes from a trusted, local source that they are familiar with (e.g., community health center, home care provider) rather than state or federal government agencies.
- There is an opportunity to increase preparedness and reduce risk among vulnerable populations at low cost by integrating information into day-to-day work, for example, by sharing information on heat-related emergencies with clients and making preparedness a part of care planning.

Participants described current efforts related to this strategy, which included:

- Regional Women, Infant and Children (WIC) offices encourage new mothers to stockpile water to use for mixing formula in the event that they cannot use the public water supply. Additionally, they educate clients that they may not be able to receive benefits delivered via Electronic Benefits Transfer (EBT) during a power outage.
- There have been some efforts in local schools to educate children on family preparedness.
- The region's Public Health Advisory Council (PHAC) had prioritized increasing preparedness as a potential regional strategy in the past and had connected with FEMA on potentially rolling out the FEMA Preparathon campaign. At that time, the PHAC felt that implementing the strategy would have been a "heavy lift."

Participants discussed next steps for implementation of this strategy, which included:

- Engage both the PHAC and the Regional Coordinating Committee (RCC) to develop a strategic, step-wise plan for conducting a regional campaign on personal preparedness.
    - Set up another FEMA presentation on conducting a personal preparedness campaign for the PHAC.
    - Determine priority populations to target for preparedness education.
    - Identify partners to engage in the planning and campaign process based on the selected target audiences.

- Review and build off of existing preparedness templates and materials for use in the campaign, such as those provided by FEMA, where possible.

- Develop a "train-the-trainer" curriculum for efficient dissemination of preparedness information. Provide trainers with campaign materials and talking points for use within their organizations and with their clients. Suggested individuals to target as trainers included:
  - Staff of organizations that serve vulnerable populations (e.g., home care providers, Meals on Wheels, Lakes Region Community Services) for promoting preparedness to their employees, clients, and patients;
  - Students enrolled in Plymouth State University (PSU) Toolkit courses, for promoting preparedness to their classmates and other students in their residence halls;
  - Staff of emergency response organizations;
  - Staff of non-profit organizations and educational institutions; and
  - Individuals involved in community organizations such as Rotary clubs, recreational programs, and faith-based organizations.
- Research ways to assist individuals experiencing food insecurity to stockpile food and other supplies to prepare for an emergency.
- Investigate opportunities to increase messaging around family preparedness provided to children in schools.

Prioritized Strategy #2: Assess and strengthen regional capacity to provide information to the public.

Forty-six percent of regional partners selected this strategy as one of their top two priorities for the region.

Participants described current efforts related to this strategy, which included:

- The Central NH Multi-Agency Coordinating Entity (MACE) has 2 trained Public Information Officers (PIOs) whom the PHN engages regularly.
- The PHN has a public communication plan which outlines the process the PHN and MACE would use to:
  - Receive information from the state level;
  - Customize the information for the region; and
  - Disseminate the message, including use of local media outlets.
- The PHN's website can display a red banner that links to information about ongoing emergencies. PHN staff encourage town-level emergency management representatives to share the link to this website, including adding the link to the town's website, so that it can serve as a centralized source of information.

Participants discussed next steps for implementation of this strategy, which included:

- Assess the public's knowledge and perception of existing emergency information sharing efforts in order to identify gaps and strategies for improvement.
- Identify opportunities to leverage existing communication modalities of organizations that serve vulnerable populations (e.g., contact lists, personal contact while providing services) for delivering emergency information to their employees, clients, and patients.

  - Identify additional organizations to partner with based on their connections with harder-to-reach populations not covered by existing partners.
- Ensure the public communication plan includes:
  - An up-to-date list of all partners that may need to be notified during an emergency;
  - Protocols specifically related to directing the public or target populations to Points of Dispensing (PODs); and
  - Diverse modalities to reach all community members, including those without access to the internet and individuals with functional needs.
- Exercise the public communication plan using a scenario that includes a need to develop multiple press releases and respond to questions from the press.
- Ensure regional partners are aware of their role in distributing information (i.e., to their employees, clients, patients, students, customers) when they receive emergency notifications.
- Ensure any materials developed as part of Prioritized Strategy #1 include information on how to sign up for town-level notification platforms.

Additional Discussion

Participants also discussed 6 additional mitigation strategies that were suggested by survey respondents. Discussion regarding each of these strategies is briefly summarized below.

Recruit, train, and retain volunteers.

Forty percent of regional partners selected this strategy as one of their top two priorities for the region.

Participants made the following observations related to this strategy:

- Participants felt strongly about this strategy as nearly all regional emergency plans rely on volunteer assistance for successful execution.
- Community members may be more likely to sign up as volunteers when they are encouraged by individuals they know and regularly interact with in their town, rather than as a result of regional-level volunteer recruitment efforts.
- The small, rural population of the PHN makes volunteer recruitment difficult.
- Prospective volunteers may be reluctant to complete a lengthy orientation process with no guarantee of when, or if, they may be activated. Additionally, participants felt that volunteer roles and responsibilities are not clearly communicated, which may be confusing to potential volunteers.
- This strategy may be difficult to implement due to factors beyond the control of the PHN, including:
  - Most adults in the region are elderly and may not be able to serve as volunteers;
  - The lack of jobs that pay a livable wage in the region means that young people often move from the area, resulting in a shrinking pool of potential volunteers; and
  - The sporadic nature and limited number of emergencies in the region can be a barrier for volunteer recruitment and retention.

- Volunteer engagement in Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC) activities has fallen recently, which volunteers attributed to few regional emergencies and not being activated during the emergencies that have occurred.

Participants described current efforts related to this strategy, which included:

- Some towns have lists of volunteers they can rely on during an emergency. For example, one town has a few volunteers that can check on individuals who rely on durable medical equipment, when needed.
- Regional plans note that each town should have a minimum of 5 ICS-trained volunteers that could respond to a regional event. However, none of the towns' emergency management directors (EMDs) have provided this list when requested by PHN staff; participants attributed this to both the extreme difficulty EMDs face when trying to recruit volunteers as well as a lack of time and funds to devote to recruitment.
- The PHN's regional plans include faith-based organizations as sources of volunteers around sheltering and providing meals during emergencies.

Participants discussed next steps for implementation of this strategy, which included:

- Identify methods to engage young adults as emergency volunteers.
- Explore opportunities to support EMDs and other town-level staff in conducting volunteer recruitment activities.
- Recruit volunteers at PHN events (e.g., emergency responses, school-based vaccination clinics).
- Identify and connect with non-emergency volunteer groups in the region to discuss involvement of their volunteer pools in emergency response. Suggested groups included:
    - Educational institutions, including PSU;
    - Faith-based organizations;
    - Rotary Clubs; and
    - Non-profit organizations.

Identify and address barriers to sharing information among regional partners during an emergency response.

Fourteen percent of regional partners selected this strategy as one of their top two priorities for the region.

Participants made the following observations related to this strategy:

- The low number of partners in the region makes information sharing among partners easier and facilitates identification of organizations that are not included in the information flow.
- There is typically no interoperability between different health care providers' electronic medical records (EMRs), which would make sharing patient information in an emergency very difficult.

Participants described current efforts related to this strategy, which included:

- There have been very few areas for improvement identified regarding information sharing among partners during recent exercises and events, such as the POD exercises associated

with school-based vaccination clinics, the 2017 partner notification drill, and the H1N1 response.

Strengthen regional capacity to meet the needs of individuals with functional needs.

Fourteen percent of regional partners selected this strategy as one of their top two priorities for the region.

Participants made the following observations related to this strategy:

- Partners serving individuals with functional needs felt that this population receives little information on how to prepare for emergencies and that they seem to be disproportionately unprepared compared to the general population.
- Individuals with special medical or behavioral health needs may not be fully aware of their medication regimens or diagnoses, which could make it difficult to meet their needs during an emergency.
- Many of the region's community members lack access to reliable transportation and would require additional assistance in an emergency should they need to relocate or evacuate.
- Staff of regional agencies servings individuals with functional needs have limited knowledge around emergency preparedness or response and would require training to assist their clients in preparing for an emergency.
- In the spring of 2018, there was a campaign in the region around awareness of heat-related illness for senior citizens.

Participants discussed next steps for implementation of this strategy, which included:

- Investigate opportunities to incorporate emergency preparedness in routine care planning for individuals with functional needs.

Provide training and exercise opportunities to partners.

Six percent of regional partners selected this strategy as one of their top two priorities for the region.

Participants described current efforts related to this strategy, which included:

- There has been significant partner involvement during recent trainings and exercises, including:
  - Annual POD exercises during school-based vaccination clinics;
  - Response facility activation and set-up drills, conducted at least every 2 years in conjunction with MACE staff; and
  - A partner notification drill in 2017 involving MACE staff, including the 2 trained PIOs.

Participants discussed next steps for implementation of this strategy, which included:

- Encourage facilities to review the Centers for Medicare and Medicaid Services (CMS) Emergency Preparedness Rule to identify their staff and organizational training and exercise needs, and share these needs with the PHN.

Strengthen engagement of regional partners in the PHN.

- **Engage additional partners.**
- **Promote the benefits of involvement in PHN activities to organizations, including senior leadership.**
- **Ensure partners are aware of the capabilities and roles of the PHN and other partners.**

No regional partners selected this strategy as one of their top two priorities for the region.

Participants made the following observations related to this strategy:

- Participants felt there should be more collaboration between the health care, behavioral health, and public health sectors.
- Given the low population density of the region, many partners only work on emergency preparedness part-time, which makes engagement in PHN activities (e.g., attending RCC meetings) challenging.
- There is a small group of individuals that work on most regional emergency preparedness efforts; participants felt that new partners should be "brought to the table."
- Representatives from behavioral health organizations noted that the system cannot meet the needs of community members on a daily basis, which makes engaging in any activities outside of direct service provision, such as emergency preparedness, very challenging.

Participants described current efforts related to this strategy, which included:

- The PHN engages with regional schools each fall through school-based vaccination clinics.
- There has historically been a representative from PSU on the MACE, although limited availability of PSU staff prevent current MACE involvement.
- PHN staff routinely meet individually with Emergency Management Directors (EMDs) of regional towns.

Strengthen regional preparedness to support health care facilities in the event of medical surge.

No regional partners selected this strategy as one of their top two priorities for the region.

Participants made the following observations related to this strategy:

- Guidance on many issues around medical surge, such as crisis standards of care or credentialing for staff sharing, would likely come from the federal and state levels during an emergency.
- It can be prohibitively expensive to stockpile materials in preparation for medical surge.
- The high demand on urgent care facilities daily may prevent them from providing significant assistance during medical surge.