2018-2019
SEACOAST 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 Seacoast 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.

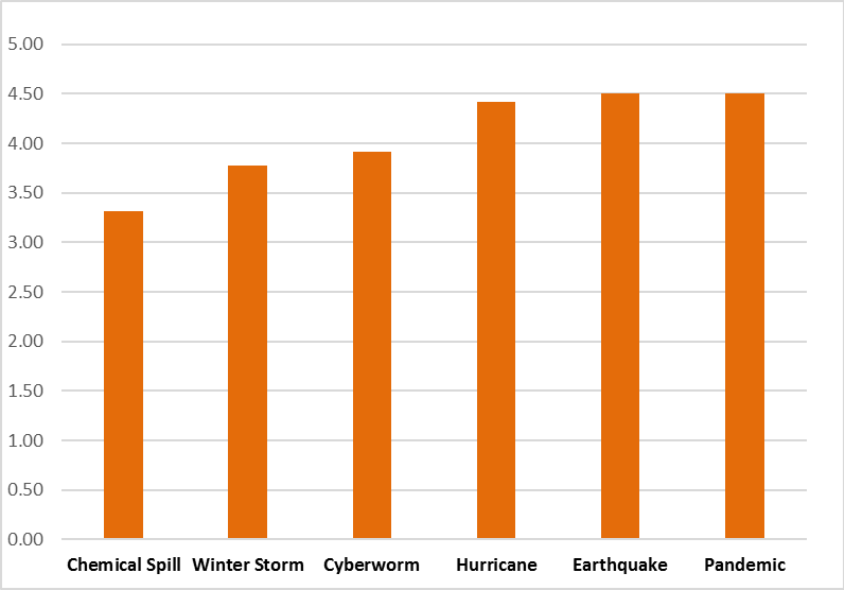
Jurisdictional Risk Assessment Results

Twenty-eight survey responses were received and 18 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).

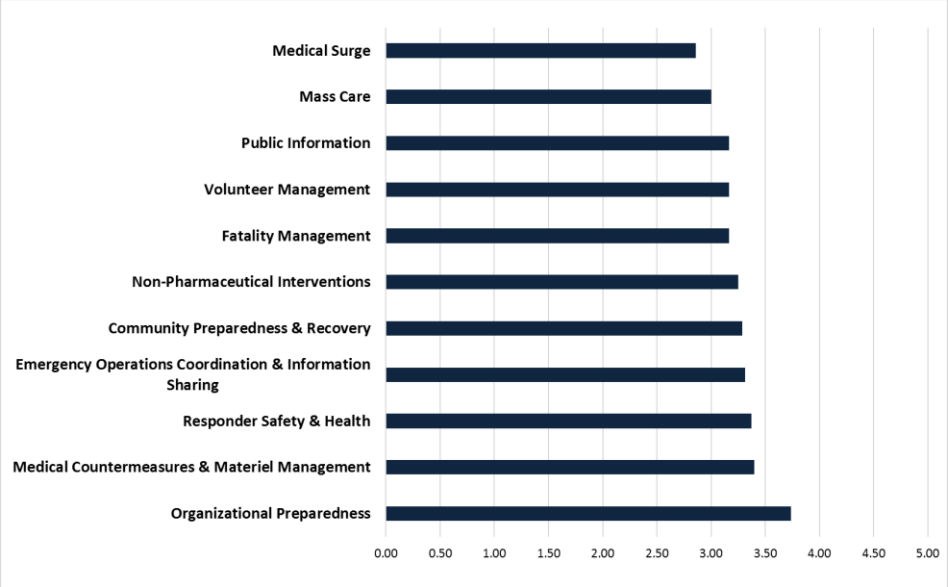
Figure 1. Impact of Each Hazard Scenario on the Health Care, Behavioral Health, and Public Health Systems



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

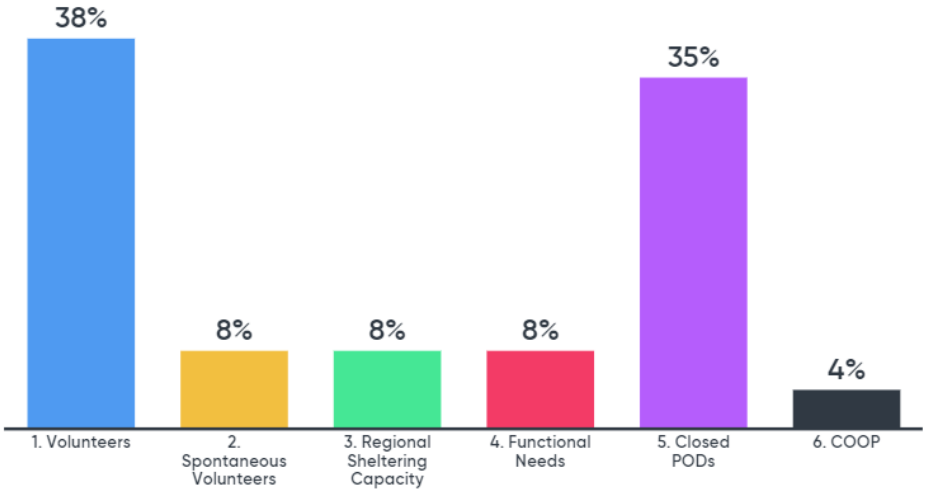
As noted above, CHI worked with the PHN PHEP Coordinator to develop a list of potential mitigation strategies for prioritization. Based on this process, the 6 strategies considered for prioritization by meeting participants were:

1. Recruit, train, and retain volunteers.
2. Develop plan to accept and manage spontaneous volunteers.
3. Build regional capacity for sheltering/mass care.
4. Strengthen regional capacity to meet the needs of individuals with functional needs.
5. Expand Closed POD sites, work with sites to develop plans, and exercise plans.

6. Foster collaboration among regional organizations in the process of developing or updating Continuity of Operations (COOP) plans.

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. Recruit, train, and retain volunteers.

2. Expand Closed POD sites, work with sites to develop plans, and exercise plans.

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

Seacoast 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
Child Care Aware of NH/Southern NH Services		✓
City of Portsmouth Fire Department	✓	
City of Portsmouth Health Department	✓	✓
ConvenientMD Urgent Care	✓	
Cornerstone Visiting Nurse Association	✓	
Exeter Hospital	✓	✓
Families First Health and Support Center		✓
Fresenius Kidney Care, Exeter Dialysis	✓	✓
Granite State Health Care Coalition/Foundation for Healthy Communities	✓	✓
HCA-Portsmouth Regional Hospital	✓	✓
Lamprey Health Care	✓	✓
Massachusetts College of Pharmacy and Health Sciences (MCPHS University)	✓	
NH Department of Health and Human Services	✓	✓
Northeast Rehabilitation Hospital Network	✓	✓
One Sky Community Services		✓
Region 6 Integrated Delivery Network	✓	
RiverWoods Retirement Community - Exeter	✓	
Rockingham County ServiceLink	✓	
Seacoast Medical Reserve Corps (MRC)	✓	
Southern New Hampshire Area Health Education Center	✓	
Strafford County Medical Reserve Corps (MRC)	✓	
Town of Deerfield	✓	
Town of Epping Fire Department	✓	
Town of Exeter Health Department		✓

ORGANIZATION	PARTICIPATION	
	SURVEY	MEETING
Town of Fremont	✓	
Town of Hampton Falls Fire Department	✓	
Town of Kensington	✓	✓
Town of Kensington Fire Department	✓	✓
Town of Kingston Fire Department	✓	
Town of New Castle Fire Department	✓	
Transformative Healthcare/Stewart's Ambulance	✓	

Attachment 2: Preparedness Rating Questions

Category	Average
Medical Surge	
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).	2.20
Activating alternate care facilities to provide care when demand overwhelms a jurisdiction's health care delivery system for a prolonged period.	2.50
Assessing and addressing the acute behavioral health needs of affected communities, including children.	2.80
Responding to infectious disease outbreaks, including screening of patients for signs, symptoms, and relevant travel and exposure history and rapidly isolate, when needed.	3.00
Responding to a chemical or radiation emergency, including decontamination of individuals.	3.00
Ensuring continued access of the public to vital health care, behavioral health, and public health services throughout response and recovery.	3.20
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.	3.33
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.	3.00
Volunteer Management	
Managing spontaneous volunteers.	3.00
Recruiting and training medical and non-medical volunteers.	3.25
Utilizing redundant communications systems to notify and activate volunteers.	3.25
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.	3.17
Fatality Management	
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.	3.00
Assisting with the safe recovery, receipt, identification, transportation, storage, and disposal of human remains, including management of contagious, chemically, or radiologically contaminated remains.	3.33
Non-Pharmaceutical Interventions	
Implementing voluntary and mandatory non-pharmaceutical interventions, including cancellation of public gatherings, travel and movement restrictions, and isolation and quarantine.	3.25
Community Preparedness & Recovery	
Addressing the unique needs of children, pregnant women, seniors, individuals with access and functional needs, etc. in planning processes.	3.19
Coordinating preparedness education with community partners, especially those serving functional needs or at-risk populations.	3.24
Offering trainings for partners to address preparedness and response gaps.	3.33
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.	3.38
Emergency Operations Coordination & Information Sharing	
Utilizing redundant communication systems and platforms to exchange information with partners to provide a common operating picture.	3.26
Activating and sustaining incident command resources (e.g., human, technical, physical space, and physical assets) to address an incident.	3.37
Responder Safety & Health	
Identifying and communicating medical and behavioral health risks to responders, including volunteers.	3.25
Facilitating access to medical and behavioral health services for responders and volunteers during and after a response.	3.38
Identifying safety and personal protective needs of responders and volunteers, and providing medical countermeasures and personal protective equipment (PPE), as needed.	3.50
Medical Countermeasures & Materiel Management	
Requesting, accepting, storing, securing, and maintaining the integrity of medical materiel.	3.25
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.	3.45
Supporting dispensing of medical countermeasures to the target population through open and closed PODs.	3.50
Organizational Preparedness	
Developing and maintaining an organizational continuity of operations plan.	3.53
Developing and maintaining an organizational emergency operations plan.	3.95

Attachment 3: Summary of Mitigation Strategy Discussion

Prioritized Strategy #1: Recruit, train, and retain volunteers.

Seventy-six 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:

- Investing in volunteer retention can decrease the need to recruit and train more volunteers. Additionally, satisfied and engaged volunteers are more likely to promote volunteering to their peers and potentially recruit them.
- During recent focus groups of senior citizens conducted to inform updates to the NH State Plan on Aging, many seniors indicated that they are interested in getting more involved in their communities and in volunteering, but are unsure of how to get started.
- Participants highlighted a need for skilled volunteers, such as those experienced in public speaking, marketing, or managing human resources, as well as for volunteers that can regularly invest in the development of the unit (i.e., volunteer a few hours per week).
- The sporadic nature of emergency activations can make volunteer retention challenging, especially given that many volunteers are interested in regular (e.g., monthly, weekly) volunteer opportunities.

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

- The Seacoast Medical Reserve Corps (MRC) unit currently has 150 registered members and about 20 active volunteers. During a recent volunteer calldown, they received about a 75% response rate. The unit is registered with the United Way Action Center.
- The MRC unit has developed a handbook for new volunteers, as well as a volunteer COOP plan.
- The MRC has a website and Facebook page that outlines how to get involved and updates from recent events.
- The MRC has monthly meetings at the Exeter Fire Department that include a training component, which participants credited with helping volunteer retention. The unit also offers the Community Emergency Response Team (CERT) training yearly; completing this training is a requirement for active volunteers. Some MRC volunteers have also offered the "You Are the Help until Help Arrives" training for other volunteers as well as community members. Certain MRC volunteers have facilitated CPR and first aid training using a fee-for-service model to raise funds for the unit.
- In addition to emergency activations, MRC volunteers also help with scheduled events. For example, they have distributed water and run first aid tents at local charity races.
- The MRC has conducted recruitment efforts at the following locations:
    - Hospitals;
    - Assisted living facilities;
    - Senior centers;
    - Great Bay Community College; and
    - Seacoast School of Technology.

- The MRC holds an annual volunteer appreciation dinner and presents a "Volunteer of the Year" award.

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

- Defining roles and developing job descriptions for volunteers. Suggested functions or "roles" included:
    - Training;
    - Outreach activities (e.g., charity runs and health fairs);
    - Volunteer management;
    - Pet sheltering;
    - Marketing and communications; or
    - Strictly response activities.
- Explore additional ways to recruit volunteers, including:
    - Efforts targeted to senior citizens, such as partnering with the local chapter of the American Association of Retired Persons (AARP).
    - Efforts targeted to younger volunteers, such as:
        - Youth or young adult groups affiliated with faith-based organizations;
        - High school students who are 18 years of age;
        - College students (educate academic advisors about opportunities for students to volunteer); and
        - Adolescent children of current MRC volunteers (when appropriate).
    - Efforts targeted to individuals trying to improve their resumes, such as participants in the Workplace Success Program.
    - Efforts targeted to individuals with work or volunteer requirements, such as Medicaid beneficiaries.
    - Efforts targeted to community-minded individuals, such as Community Action Programs and members of the National Guard.
- Create and distribute a flyer about the MRC and the steps to getting involved at trainings the MRC offers to community members (e.g., CPR, first aid, "You Are the Help Until Help Arrives").
- Develop a standardized intake protocol (e.g., form, interview) to identify volunteer skills, abilities, and interests. Use the information gained during intake to identify roles and functions for volunteers that align with their skills, abilities, and interests.
- Identify "cognitive" (versus "physical") tasks that can be done by older volunteers or those with physical limitations, such as scheduling, making phone calls, or developing concepts and protocols for volunteer recruitment and training.
- Continue to invest in volunteer retention. Suggested activities included:
    - Provide volunteers with regular updates through social media and newsletters;
    - Increase efforts around volunteer recognition, such as recognition in local media;
    - Identify opportunities to engage volunteers outside of regional emergency activations, such as more scheduled events or emergencies in other regions; and
    - Identify tangible rewards or benefits for volunteering, such as potential tax deductions (e.g., mileage) or arranging discounts at local businesses for MRC members.

- Identify and connect with non-emergency volunteer groups in the region to discuss involvement of their volunteer pools in emergency response. Suggested groups included:
    - Those affiliated with private businesses;
    - The Friends Program; and
    - Families First Health and Support Center.

Prioritized Strategy #2: Expand Closed POD sites, work with sites to develop plans, and exercise plans.

Seventy 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:

- Closed PODs result in fewer clients at Open PODs and thus decrease the number of Open POD volunteers needed.
- In order to become a Closed POD, an organization needs either internal clinical staff (e.g., occupational health clinic) or a relationship (e.g., Memorandum of Understanding (MOU)) with a third-party organization to provide clinical staff, which can be a barrier to becoming a Closed POD site.
- Some regional health care partners noted that there is a need to establish policies at the state level regarding availability of countermeasures for staff families prior to their organizations establishing Closed POD agreements with the PHN. It was noted that the NH DHHS is currently working to resolve this issue.

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

- The region currently has 5 Closed PODs: Cornerstone Visiting Nurse Association (VNA); RiverWoods Retirement Community; Langdon Place of Exeter; Rockingham County Complex; and Lamprey Health Care.
- The PHN has attempted to establish new Closed POD sites at regional assisted living facilities and large employers by holding meetings and phone calls with organizational representatives, as well as disseminating flyers, instructions, and template plans. Although organizations have expressed interest, they have not followed through with signing agreements or developing plans.
- NH DHHS is currently in the process of forming a Closed POD workgroup to identify strategies to increase the number of Closed POD sites across the state, including ways to make becoming a Closed POD more accessible.

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

- Prioritize a set number of organizations to target as potential Closed POD sites each year.
    - Suggested organizational criteria included:
        - Organizations with occupational health clinics;
        - Organizations with a large number of employees (e.g., top 10 largest employers in the region) or individuals served;
        - Critical infrastructure organizations (e.g., health care, community mental health centers, firefighters, EMTs, public works, banks);

        - Organizations that serve individuals with challenges accessing transportation, mobility issues, and other functional needs; and
        - Organizations that work in the community or are frequently exposed to the public, such as home visiting programs and other child welfare programs.
    - Suggested organizations included:
        - Assisted living and long-term care (LTC) facilities;
        - Lonza;
        - Liberty Mutual;
        - Planet Fitness (corporate headquarters);
        - High Liner Foods; and
        - Service Credit Union.
- Identify novel methods of contacting potential Closed POD sites that may be more effective in encouraging them to develop plans. Suggestions included:
    - Leverage PHN partners' existing connections.
    - Work with representatives of existing Closed PODS to conduct outreach to organizations of the same type or reference them as examples when reaching out to like organizations.
    - Provide Health Officers with promotional materials and talking points about becoming a Closed POD to share with businesses during health inspections. Explore options for PHN staff to travel with Health Officers to speak with these businesses.
    - Investigate the possibility of working with priority organizations that do not have clinical staff on site to become Closed PODs. Share template MOUs that potential sites can use to access external clinical staff.
    - Investigate opportunities to provide clinical staff with continuing education credits for partnering with Closed PODs who lack internal clinical staff.

Additional Discussion

Participants also discussed 4 additional mitigation strategies that were suggested by survey respondents. Discussion regarding each of these strategies is briefly summarized below.

Develop plan to accept and manage spontaneous volunteers.

Sixteen percent of regional partners selected this strategy as one of their top two priorities for the region. Participants highlighted the importance of vetting spontaneous volunteers, especially if they may be exposed to hazardous materials or be asked to work with vulnerable clients, such as children, elderly adults, or individuals with physical and intellectual disabilities.

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

- Create a registration website that could be readily available to register spontaneous volunteers in the event of an emergency. Ensure this website can identify volunteers' skills or abilities that could be used to assign them to an appropriate role.
- Develop a communication plan for instructing spontaneous volunteers on how to help in the event of an emergency.
- Train active MRC volunteers to manage and provide just-in-time (JIT) training to spontaneous volunteers.

- Identify roles that spontaneous volunteers may be able to assist with, such as management of donated supplies.
- Consider engaging interns to draft a spontaneous volunteer management plan.

Build regional capacity for sheltering/mass care.

Sixteen 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:

- Previous regional challenges around sheltering have included inadequate numbers of volunteers, pet and service animal sheltering, and addressing the needs of individuals who rely on electricity.
- Although the region has shelter resources in trailers, the resources (e.g., cots and bedding) would likely not be adequate if multiple shelters were opened in the region at once.
- During a localized event that results in a shelter activation, potential shelter staff are likely affected by the event themselves and may not be able to assist. Therefore, shelter plans should include contingencies for pulling in staff from neighboring towns or regions.

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

- Every town in the region has an assigned Shelter Manager.
- In 2013, the region convened a shelter sub-committee that developed a regional shelter plan that includes materials such as job action sheets, client registration forms, and volunteer sign-in sheets. These plans and template documents are currently in the region's shelter trailers.
- The regional plan is, in part, designed to support individuals who rely on electricity during a power outage, as these individuals have historically relied on and overwhelmed hospitals.
- PHN partners developed an algorithm for Emergency Management Directors (EMDs) to use when considering opening a regional shelter.

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

- Ensure plans for sheltering or mass care include provisions for staff who are vetted and trained in child care.
- Explore options for adapting plans around low-flow oxygen during pandemic influenza to assist individuals who rely on portable oxygen in shelters.
- Strengthen regional ability to provide transportation to emergency shelters, especially for individuals with mobility challenges or difficulty accessing transportation.

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

Sixteen 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:

- One Sky Community Services coordinates services for individuals with developmental disabilities and acquired brain injuries, which are provided by vendor agencies. Although all

vendors have emergency plans in place, there is no coordinated regional plan to ensure continuity of services in an emergency.

- US Department of Health and Humans Services' (DHHS') emPOWER data can be used to inform planning regarding Medicare beneficiaries who rely on electricity dependent medical equipment by zip code. In an emergency, states can request identifiable information from US DHHS to assist with emergency response and identify community members with special medical needs.

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

- Some regional VNAs and hospice providers have informal agreements with local EMDs so that municipalities can check on patients in an emergency if VNA staff are unable to.
- Rockingham VNA and Hospice has created standardized forms for patients with their emergency contacts and potential unique needs in an emergency. These forms are updated periodically with patients, especially as their needs change.
- The PHN has previously collaborated with One Sky Community Services, Great Bay Services, and the UNH Institute on Disability to offer a Train-the-Trainer on building emergency kits and plans for individuals with disabilities.

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

- Support One Sky Community Services in developing a coordinated regional plan based on vendor organizations' emergency plans.
- Facilitate communication between organizations that serve individuals with functional needs and local EMDs to ensure that the EMDs are aware of those in their community who may face unique challenges in an emergency.
- Collaborate with Community Action Programs, especially programs that serve individuals experiencing homelessness, to identify the best way to contact their clients in an emergency.
- Explore opportunities to train first responders on interacting with individuals with functional needs, especially those with developmental disabilities or who have difficulty communicating.

Foster collaboration among regional organizations in the process of developing or updating COOP plans.

Eight 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:

- This year, there is a new licensing requirement for child care providers that requires them to develop COOP plans.
    - Although they have been offered resources around COOP planning, such as templates and workshops, there is wide variability in the status and thoroughness of these plans.
    - A major concern for child care facilities around COOP planning involves access to the resources required (e.g., staffing, supplies) for sustained operations.
    - Decreased access to child care can prevent emergency response staff and volunteers from responding.

- The wide variability of overall preparedness, plan status, and essential functions of regional agencies and municipalities can make it difficult to develop templates and training materials that will apply to most partners.

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

- Identify priority sectors to target for assistance with and coordination of COOP planning, such as One Sky Community Services' vendor agencies.
- Ensure COOP plans contain redundancies for critical services and supplies in the event that routine sources are not functional during an emergency.
- Encourage and support regional-level collaboration when developing or evaluating COOP plans, including:
    - Work through regional- or state-level associations of organizations such as hospitals, senior centers, or LTC facilities to convene partners of the same type to compare plans;
    - Consider convening groups of like organizations to work on sections of COOP plans and share ideas and promising practices; and
    - Work to deconflict plans by ensuring multiple towns or organizations (e.g., hospitals) do not rely on the same limited resources during an emergency.