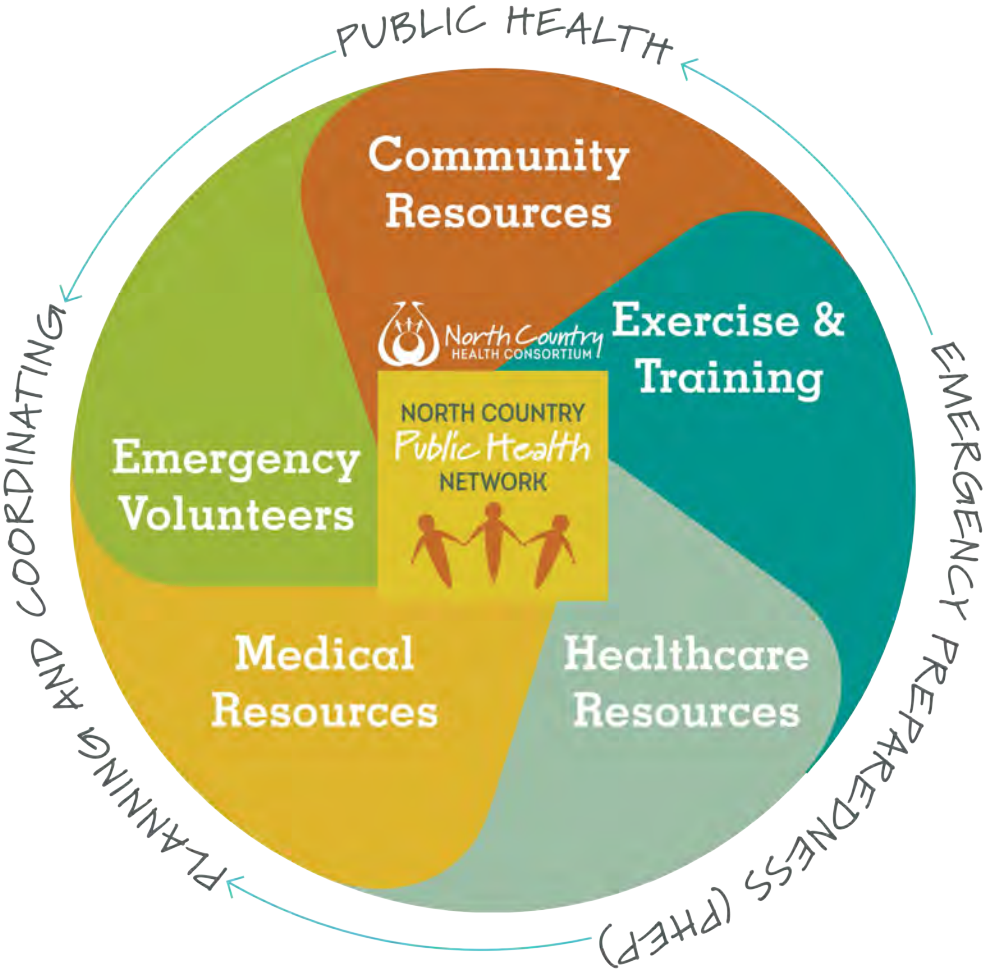
Regional Public Health Emergency Annex (RPHEA)

North Country Public Health Network



March 2020

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REGIONAL PUBLIC HEALTH EMERGENCY ANNEX

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1 PURPOSE

The Regional Public Health Emergency Annex (RPHEA) provides the organizational and operational framework to prepare for, respond to, and recover from public health emergencies in the North Country Public Health Region (PHR).

The RPHEA[1] is intended to be an annex to the Local Emergency Operations Plan (LEOP)[2] for each town in the PHR. The RPHEA is a supporting document to the LEOP and does not replace or supersede it.

The North Country Public Health Network (PHN) collaborates with partner agencies to develop public health emergency communications, services, and programs that do not discriminate based on race, color, religion, nationality, sex, age, disability, English proficiency, economic status, immigration status, sexual orientation, or gender identity. The RPHEA provides for the equitable and impartial provision of public health response services in compliance with state and federal laws. Each PHN employs a Public Health Emergency Preparedness (PHEP) Coordinator to support planning, preparedness, and response efforts.

2 SCOPE

During a public health emergency, the regional Multi-Agency Coordination Entity (MACE) implements the RPHEA to support:

- Multi-agency coordination and information sharing
- Public information coordination
- Staff and volunteer coordination
- Resource coordination

The MACE supports activation, operations, and demobilization of public health response facilities to provide emergency public health services. The MACE does not assume command and control of local operations, including those at local response facilities.

The RPHEA includes three appendices (Activation, Operations, and Demobilization) and task lists to support the following public health capabilities:

- Fatality Management (naturally occurring mass fatalities only)
- Mass Care
- Medical Countermeasures Dispensing
- Medical Materiel Management & Distribution
- Medical Surge

[1] The RPHEA operates under the Incident Command System (ICS) and is compliant with the National Incident Management System (NIMS) in accordance with existing state and local emergency operations plans.

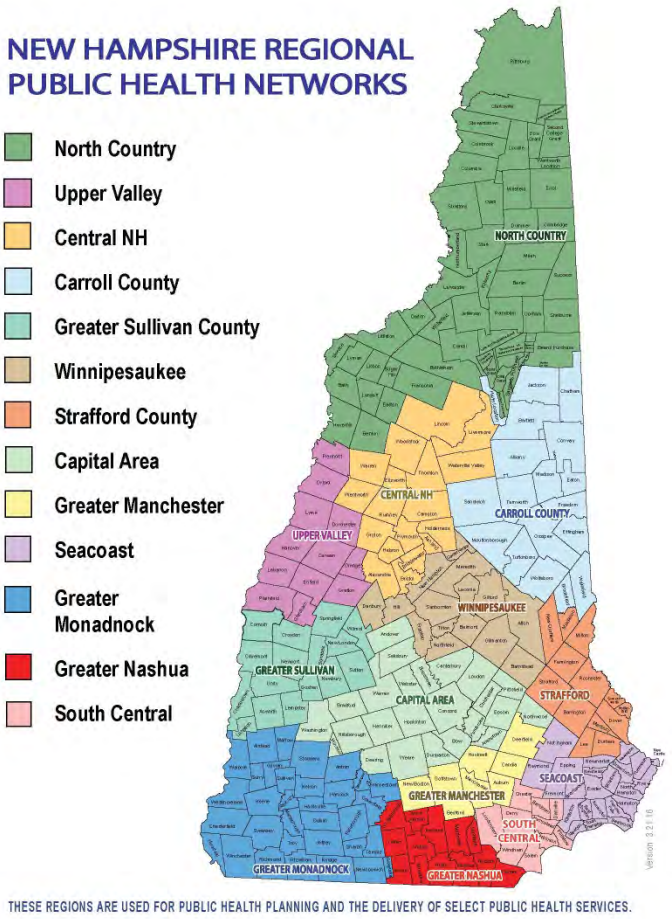
[2] The legislative authority for each town in the PHR is responsible for designating NIMS as the basis for local incident management. As an annex to the LEOPs, the RPHEA operates as an extension of local incident management and follows NIMS guidelines.

3 SITUATION

In New Hampshire, local community partners collaborate to develop regional response plans for public health emergencies. This section describes the planning environment for the PHR.

3.1 REGIONAL CHARACTERISTICS

New Hampshire Department of Health and Human Services (DHHS) designates the service area for each PHN. The North Country PHR is one of thirteen regions statewide.



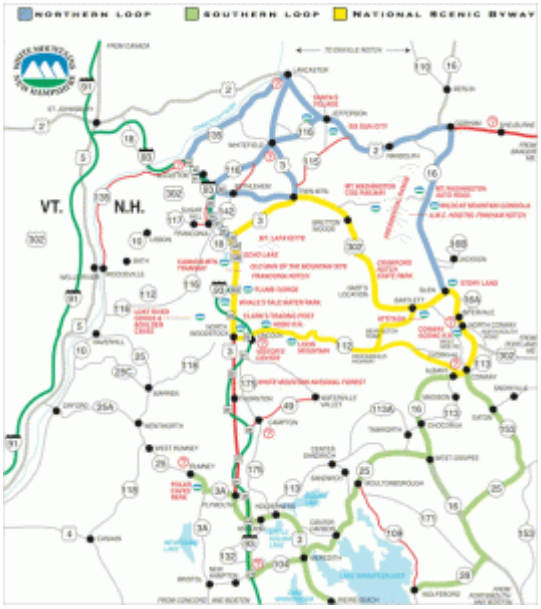
3.1.1 Location & Geography

The North Country PHR includes the following communities:

Bath, Benton,Berlin,Bethlehem, Cambridge, Carroll, Clarksville, Colebrook, Columbia, Dalton, Dixville, Dummer, Easton, Errol, Franconia, Gorham, Haverhill, Jefferson, Kilkenney, Lancaster, Landaff, Littleton, Lyman, Milan, Millsfield, Monroe, Northumberland, Odell, Pittsburg, Randolph, Sheltburne, Stark, Stewartstown, Stratford, Success, Sugar Hill, and Whitefield. Additonally unincorporated areas including: the 2nd. Collegiate Grant, A.G. Grant, Dixville Notch, and Wentworth Location.

The year round resident population of these communities is approximately 68,000 with many thousands more visiting the north country of New Hampshire throughout the year.

The PHR geographically aligns with Northern Grafton and all of Coos County.



North Country Public Health Region

3.1.2 Neighboring Jurisdictions

PHN	**"Central" town**
Capital Area	Concord
Carroll County	Ossipee
Central NH	Plymouth
Greater Manchester	Manchester
Greater Monadnock	Keene
Greater Nashua	Nashua
Greater Sullivan County	Newport
North Country	Littleton
Seacoast	Exeter
South Central	Derry
Strafford County	Rochester
Upper Valley	Lebanon
Winnipesaukee	Laconia

The PHR is bordered by the Central NH, Carroll County, and Upper Valley PHRs. The following table provides characteristics for major neighboring jurisdictions.

Table 1: Neighboring Jurisdictions & Key Characteristics

Jurisdiction	Distance	Population	Notations
Concord, NH	85 miles	42,537	State Offices, State Emergency Operations Center (SEOC), State Response Facilities
Portsmouth, NH	130 miles	21,426	State Response Facilities
Boston, MA	152 miles	650,281	MSA
Central NH PHR	44	7,000	Plymouth State College
Upper Valley	76	11,416	Dartmouth College

3.1.3 Demographics

The North Country PHR has a population of 52,053 as of 2017 and ranks 9th out of thirteen regions for population. Twenty percent of the population live in the city of Berlin as the main population center.

3.1.3.1 Population by Age

Certain emergencies may require that all at-risk individuals be seen at the response facilities to receive emergency resources or services (e.g., vaccination to protect from pandemic influenza). The following table provides population estimates by age group for the region and by the response facility catchment area.

Table 2: Population by Age Groups

Response Facility	Total Population[3]	Age Groups[4]		
		0-19	20-64	65+
Berlin POD	13,795	201	1,450	1,164
Lancaster POD	11,744	174	1,235	887
Littleton POD	7,492	101	536	578
Haverhill POD	7,691	61	595	542
Colebrook POD	4,734	37	442	365
Region	52,053	574	4,258	3,536

3.1.3.2 Households

Certain emergencies may allow for an individual from each household to pick up emergency resources (e.g., medication, bottled water, etc.) for all household members. Head of Household (HOH) distribution and dispensing significantly reduces the number of individuals seen at the response facility (e.g., Point of Dispensing (POD), etc.).

A household is an occupied housing unit that is either rented or owned. Occupants of housing units are further classified as either family households or non-family households. The following tables provide household estimates for the region and by the response facility catchment area. Further, the tables compare hourly throughput of individuals to hourly throughput of households within a 36-hour dispensing period. These throughput calculations are based on a scenario in which initial dispensing must occur within 48-hours of notice with mobilization of public health operations occurring in the first 12-hours (e.g., Anthrax incident).

[3] Total Population (B01003), 2011-2015 American Community Survey 5-Year Estimates.
[4] Age and Sex (B01001), 2011-2015 American Community Survey 5-Year Estimates.

Table 3: Total Population, Total Households, Households by Household Type & Throughput Calculations

Response Facility	Total Population	Total Households	Ave. Size	Household Type[5,6]			Hourly Throughput	
				Family	Non-Family		36-Hours	
				Total	Non-Family	Live Alone	Individuals	HOH
Berlin POD	15,002	6,609	2.3	4,121	2,488	2,172	417	184
Lancaster POD	4,567	1,948	2.3	1,202	746	553	127	54
Littleton POD	4,859	2,307	2.1	1,459	848	694	135	64
Haverhill POD	8,117	3,117	2.6	2,047	1,070	850	225	87
Colebrook POD	11,911	5,241	2.3	3,349	1,892	1,615	331	146
Region	7,499	3,193	2.4	2,061	1,132	1,038	208	89
	52,053	22,456	2.3	14,265	8,191	6,927	1,446	624

A family household is one in which at least one person is related to the householder by birth, marriage, or adoption. A householder is the person who rents or owns the housing unit. The following tables provide family household estimates for the region and by response facility catchment area.

Table 4: Family Households by Size, Households with Children & Single Parent Households

Response Facility	Total Households	Family Households[7,8]								
		% Family	Total Family	Ave. Size	Household Size				Children <18[9]	Single Parent
					2	3	4	5+		
Berlin POD	6,609	62.4	4,121	2.7	2,351	940	579	251	2,473	1,193
Lancaster POD	1,948	61.7	1,202	2.8	702	220	127	153	905	279
Littleton POD	2,307	63.2	1,459	2.6	910	318	135	96	772	263
Haverhill POD	3,117	65.7	2,047	2.8	1,101	461	245	240	1,397	445
Colebrook POD	5,241	63.9	3,349	2.8	1,817	647	556	329	2,365	836
Region	3,193	64.6	2,061	2.8	1,160	347	409	145	1,526	641
	22,456	63.5	14,265	2.8	8,062	2,938	2,051	1,214	9,391	3,657

A non-family household is one in which the householder lives alone or shares the housing unit with unrelated individual(s). A householder is the person who rents or owns the housing unit. The following table documents non-family households for the region and by response facility catchment area.

Table 5: Non-Family Households by Size & Age of Householder

Response Facility	Total Households	Non-Family Households[10,11]					
		% Non-Family	Total Non-Family	Household Size		Householder Age	
				1	2+	15-64	65+
Berlin POD	6,609	37.6	2,488	2,172	316	1,297	1,191
Bethlehem POD	1,948	38.3	746	553	193	516	230
Colebrook POD	2,307	36.8	848	694	154	534	314
Haverhill POD	3,117	34.3	1,070	850	220	667	403
Lancaster POD	5,241	36.1	1,892	1,615	227	1,159	733

[5] Households and Families (S1101), 2011-2015 American Community Survey 5-Year Estimates.
[6] Household Type (Including Living Alone) (B11001), 2011-2015 American Community Survey 5-Year Estimates.
[7] Household Type by Household Size (B11016), 2011-2015 American Community Survey 5-Year Estimates.
[8] Households and Families (S1101), 2011-2015 American Community Survey 5-Year Estimates.
[9] Household Type for Children Under 18 Years in Households (B09005), 2011-2015 American Community Survey 5-Year Estimates.
[10] Household Type by Household Size (B11016), 2011-2015 American Community Survey 5-Year Estimates.
[11] Non-Family Households by Living Alone by Age of Householder (B11010), 2011-2015 American Community Survey 5-Year Estimates.

Response Facility	Total Households	Non-Family Households[10,11]					
		% Non-Family	Total Non-Family	Household Size		Householder Age	
				1	2+	15-64	65+
	3,193	35.5	1,132	1,038	94	761	371
Region	22,456	36.5	8,191	6,927	1,264	4,948	3,243

3.1.3.3 Economic Disadvantage

Households with low income may face barriers to accessing services and experience disproportionate disaster impacts. The following table documents the proportion of households living below 100% and 200% of the federal poverty level (FPL).

3.1.3.4 Access & Functional Needs

Individuals with access and functional needs may require additional assistance and specialized staff and equipment to access emergency public health services. The following tables document population estimates for individuals who may require Functional Needs Support Services (FNSS) during and after an emergency. The PHN collaborates with partner agencies that serve individuals with access and functional needs to provide FNSS to use in response to a public health emergency and at public health response facilities. The following tables display estimates for the number of people with access and functional needs, functional needs by age, and the number of people with multiple functional needs as well as the number of people by type of functional need.

Table 6: Access & Functional Needs by Age & Number of Needs

Response Facility	Total Population[12]	Individuals with Functional Needs[13]		Functional Needs by Age[14]					Individuals by Number of Needs[15]	
		Total	%	<5	5-17	18-64	65-74	75+	1	2+
Berlin POD	13,795	2,815	20.4	0	201	1,450	285	879	1,526	1,289
Lancaster POD	4,491	704	15.7	0	75	357	119	153	371	333
Littleton POD	4,734	844	17.8	0	37	442	228	137	441	403
Haverhill POD	7,691	1,198	15.6	0	61	595	263	279	523	675
Colebrook POD	11,744	2,296	19.6	0	174	1,235	443	444	1,175	1,121
Region	7,492	1,215	16.2	0	101	536	270	308	610	605
	49,947	9,072	18.2	0	649	4,615	1,608	2,200	4,658	4,436

Table 6: Access & Function Needs by Type of Functional Need

Response Facility	Individuals by Type of Functional Need[16]						
	Total	Hearing	Vision	Cognitive	Ambulatory	Self-Care	Independence
Berlin POD	2,815	1,038	387	1,124	1,380	486	869
Lancaster POD	704	275	163	198	339	196	259
Littleton POD	844	319	185	329	421	89	229
Haverhill POD	1,198	356	182	494	623	275	536
Colebrook POD	2,296	774	374	869	1,212	384	749
Region	1,215	322	110	382	805	344	466

[12] Total civilian noninstitutionalized population.
[13] Disability Characteristics (S1810), 2011-2015 American Community Survey 5-Year Estimates.
[14] Disability Characteristics (S1810), 2011-2015 American Community Survey 5-Year Estimates.
[15] Age by Number of Disabilities (C18108), 2011-2015 American Community Survey 5-Year Estimates.
[16] Disability Characteristics (S1810), 2011-2015 American Community Survey 5-Year Estimates.

	9,072	3,100	1,404	3,405	4,786	1,776	3,116

3.1.3.5 Predominant Languages

Non-English speakers and individuals with low-literacy in their native language may require interpreter services to access emergency information and services. The following table documents the most common languages spoken at home other than English and details languages with a high number of individuals who speak English less than very well. This table is used to plan for and prioritize translation and interpretation resources.

Table 9: Languages Spoken at Home for Those Who Speak English Less Than Very Well, by Response Facility

Language[17]	North Country Public Health Region	POD	ACS	NEHC
French		Berlin	Berlin	Berlin
French		Colebrook	Colebrook	Colebrook

During an emergency, the MACE coordinates with partner agencies to translate written information and to arrange for onsite, telephone, or video interpretation services. The following translation and interpretation resources have been identified.

Table 7: Translation & Interpretation Resources

Service/Organization	Languages	Contact	Number	Available Services
NH "211"	Various	TTY Number: 603-634-3388	211	Interpretation
NH Department of Education, 2015-2016 Directory of NH translators/Interpreters (ASL and spoken language) School Language Program	Various	education.nh.gov/instruction	603-271-3494	Spoken Languages/ ASL
Cross Cultural Communication Systems	Various	http://www.cccsorg.com/	888-678-2227	Spoken Language
Language Bank of Lutheran Social Services	Various	http://www.thelanguagebank.org/	603-224-5473	ASL and Spoken Language
[Insert Nextalk Innovative Communication Software Language-Based Media]	Various	http://www.nextalk.com/	801-274-6001	Text relay, point to point video
Language Line	240+ languages	SEOC, Emergency Support Function 8 (ESF-8)	(603) 223-3729	Translation of written materials during emergencies

[17] Languages Spoken at Home by Ability to Speak English (B16001), 2011-2015 American Community Survey 5-Year Estimates.

See also:
Resource List of Communication Access Service Providers↗[18]
Directory of NH Translators/Interpreters↗[19] (note: list not specific to medical interpretation)

3.1.3.6 No Vehicle Households

An estimated 1,651 households in the PHR do not have access to a vehicle. The following table documents characteristics of no vehicle households for the region and by response facility catchment area.

Table 8: No-Vehicle Households by Size, Age & Tenure of Householder & Number of Workers Present

Response Facility	Households	No Vehicle Households[20,21,22,23]								
		Total	Household Size		Householder Age		Tenure		Workers	
			1	2+	15-64	65+	Own	Rent	0	1+
Berlin POD	6,609	585	433	152	304	281	145	440	481	104
Bethlehem POD	1,948	101	73	28	77	24	18	83	83	18
Colebrook POD	2,307	141	94	47	91	50	60	81	98	43
Haverhill POD	3,117	113	77	36	77	36	41	72	60	53
Lancaster POD	5,241	381	259	122	171	210	187	194	330	51
Littleton POD	3,193	330	290	40	232	98	66	264	224	106
Region	22,456	1,651	1,226	425	952	699	517	1,134	1,276	375

3.1.4 Critical Public Health & Healthcare Infrastructure

The following critical facilities in the North Country PHR may require priority public health services to sustain their critical public health and healthcare services during an emergency.

Table 9: Critical Facilities & Infrastructure

Facility	Town	# Employees	Service Type
Androscoggin Valley Hospital	Berlin	340	Health Care
Cottage Hospital	Haverhill	250	Health Care
Littleton Regional Hospital	Littleton	510	Health Care
Upper Connecticut Valley Hospital	Colebrook	143	Health Care
Weeks Memorial Hospital	Lancaster	320	Healthcare

[18] External link: https://www.healthynh.com/images/PDFfiles/cultural-effectiveness/AppendixG82616.pdf.
[19] External link: https://www.education.nh.gov/instruction/integrated/title_iii_information_translators.htm.
[20] Household Size by Vehicles Available (B08201), 2011-2015 American Community Survey 5-Year Estimates.
[21] Vehicles Available by Age of Householder (B25045), 2011-2015 American Community Survey 5-Year Estimates.
[22] Tenure by Vehicles Available (B25044), 2011-2015 American Community Survey 5-Year Estimates.
[23] Number of Workers in Household by Vehicles Available (B08203), 2011-2015 American Community Survey 5-Year Estimates.

3.1.5 Transportation

U.S. Route 93 runs north/south through the North Country PHR to the Vermont State line while U.S. Route 3 continues northerly to the U.S./Canada border in the Town of Pittsburg.

The following table lists other roadways in the region.

Table 10: Transportation Routes

Highway	Direction	Towns	Notations
U.S. Route 3	N/S	From Franconia to Pittsburg	
U.S. Route 2	E/W	From Maine to Vermont State Line	
N.H. Route 16	N/S	From Gorham to Wentworth's Location	

The following table lists transportation assets available to the MACE during response.

Table 11: Transportation Assets

Name	Asset	Address	Phone	County	Sub Region
Littleton Regional Hospital	3 van seats, 2 wheelchair spaces	600 St. Johnsbury Rd., Littleton, NH 03561	603. 444.9000	N. Grafton	Pod Group 4 (Littleton)
Littleton Area Senior Center, Grafton County Senior Citizens Council	16 van seats, 2 wheelchair spaces	Cottage St., Littleton, NH 03561	603. 444.6050	N. Grafton	POD Group 4 (Littleton)
Service Link	12 van seats, 2 wheelchair spaces	38 Cottage St., Littleton, NH 03561	603. 444.0271	N. Grafton	POD Group 4 (Littleton)
North Country Health Consortium Friendship House	7 van seats	2957 Main Street Bethlehem, NH 03574	603. 869-2210	N. Grafton	POD Group 5 (Bethlehem)
Common Ground / White Mountain Mental Health	12 van seats, 2 wheelchair spaces	Common Ground 29 Maple Street, Box 599 Littleton, NH 03561	603. 444.6894	N. Grafton	POD Group 4 (Littleton)
North Country Charter Academy	Unknown	260 Cottage Street Suite A Littleton, NH 03561	603. 444.1535	N. Grafton	POD Group 4 (Littleton)
White Mountain School	Unknown	West Farm Road Bethlehem, NH 03574	603. 444.2928	N. Grafton	POD Group 5 (Bethlehem)
Tri.County CAP / North Country Transit	78 van seats, 8 wheelchair spaces	31 Pleasant St. Berlin , NH 03570	603.752.1741	Coös	POD group 2 (Berlin)

See also:

NH Public Transportation Map↗[24]
Park & Ride Locations↗[25]
Regional Communication Plans and Directories↗[26]

3.1.6 Points of Interest

The following points of interest are in the North Country PHR and contribute to daily or seasonal population increases.

Table 12: Major Points of Interest & Seasonal Population Increases

Point of Interest	Town	# People	Notations
White Mountain National Forest	Franconia thru Northern N.H.	Varies	Several campgrounds and hiking trails are located within the National Forest which covers approximately 800,000 acres receives millions of visitors annually.
Franconia Notch State Park	Franconia	Varies	Franconia Notch State Park encompasses 6692 acres and welcomes several hundred thousands visitors year round.

3.1.7 Special Events

The following special events occur in the North Country PHR and contribute to temporary population increases.

Table 13: Special Events & Temporary Population Increases

Special Event	Town	# People	Notations
Lancaster Fair	Lancaster	10,000	Runs from Sept. 3-7, 2020
North Haverhill Fair	North Haverhill	5,000	Runs from July 22-26, 2020
Moose Festival	Colebrook	3,000	Runs from Aug. 28-29, 2020

3.1.8 Large Employers

The following large employers in the North Country PHR contribute to temporary population increases. Large employers may serve as settings to reach many people with public information or emergency services.

Table 14: Large Employers

Employer	Town	# Employees	Notations
Grafton County Complex	Haverhill	325	Nursing Home and jail are Closed PODs
Cottage Hospital	Haverhill	250	Health Care
Littleton Regional Hospital	Littleton	510	Health Care
Walmart	Littleton	181	Retail
Burndy Corporation	Littleton	170	Manufacturing
Tender Corporation	Littleton	125	Manufacturing
Lowes Home Improvement	Littleton	108	Retail
Shaw's Supermarket	Litteton	114	Retail
Weeks Memorial Hospital	Lancaster	320	Health Care
Country Village Nursing Home	Lancaster	120	Long Term Care Closed POD

[24] External link: https://www.nhtmc.com/Rail_and_Transit/state_transportation_map.pdf.
[25] External link: https://www.nh.gov/dot/programs/rideshare/lots/.
[26] External link: https://www.nh.gov/dot/programs/scc/rcc.htm.

Employer	Town	# Employees	Notations
Androscoggin Valley Hospital	Berlin	340	Health Care
Federal Corrections Institution	Berlin	275	Federal Prison System
Northern NH Correctional Facility	Berlin	198	State Prison System

See also:
NH Community Profiles↗[27]

3.1.9 Schools & Child Care Facilities

The following schools and large child care facilities are in the North Country PHR and may serve as settings to reach many people with public information or emergency services.

Table 15: Schools with Student and Staff Population Estimates

Town	School	Grades	# Students	# Staff	Notes
SAU 3 Berlin	Brown School	K-2	**243**	**20**	
SAU 3 Berlin	Hillside School	3-5	231	20	
SAU 3 Berlin	Berlin Middle School	6-8	270	23	
SAU 3 Berlin	Berlin High School	9-12	435	40	Regional POD Site
SAU 7 Pittsburg	Pittsburg School	K-12	101	20	
SAU 36 Lancaster	Lancaster Elementary	K-8	373	40	Regional POD Site
SAU 36 Lancaster	Whitefield Elementary	K-8	297	32	
SAU 36 Lancaster	White Mountain Regional High School	9-12	393	40	
SAU 84 Littleton	Mildred C Lakeway Elementary School	K-6	372	38	
SAU 84 Littleton	Daisy Bronson Middle School	7-8	117	12	
SAU 84 Littleton	Littleton High School	9-12	216	26	Regional POD Site
SAU 23 Haverhill	Bath Village School	K-6	82	9	
SAU 23 Haverhill	Haverhill Cooperative Middle School	4-8	251	27	Regional POD Site
SAU 23 Haverhill	Woodsville Elementary School	K-3	233	22	
SAU 23 Haverhill	Woodsville High School	9-12	223	24	
SAU 7 Colebrook	Colebrook School District	k-12	358	16	Regional POD Site
SAU 7 Colebrook	Stewartstown Community School	K-8	78	9	
SAU 35 Bethlehem	Bethlehem Elementary School	K-6	170	20	
SAU 35 Bethlehem	Lafayette Regional	K-6	112	12	
SAU 35 Bethlehem	Landaff Blue School	K-3	21	2	
SAU 35 Bethlehem	Lisbon Regional	K-6	159	19	
SAU 35 Bethlehem	Profile Jr./Sr. High School	7-12	240	26	Regional POD Site

[27] External link: http://www.nhes.nh.gov/elmi/products/cp/.

See also:
School and District Profiles↗[28]
Non-Public Schools By Town↗[29]
Child Care Licensing Unit↗[30]

3.2 Regional Hazard Profile

In 2019 the North Country PHN conducted a Jurisdictional Risk Assessment (JRA) (previously called a Hazard Vulnerability Assessment (HVA)) to assess the potential impacts of hazards on the healthcare, behavioral health, and public health systems and to identify mitigation strategies. Hazards assessed in 2018 included earthquake, flood, heat wave, hurricane, pandemic, and winter storm.

The North Country PHN and the regional coordinating committee review available state and local risk assessments annually to:

- Identify services needed to mitigate regional health risks
- Identify existing services that support the mitigation strategies
- Review progress on implementing mitigation strategies

Additionally, in order to be eligible for federal hazard mitigation funding, municipalities in the PHR are required to develop Hazard Mitigation Plans that are compliant with the Disaster Mitigation Act of 2000.

4 Assumptions

1. A public health emergency is a multi-jurisdictional event requiring a multi-disciplinary response. Effective preparedness, response, and recovery rely upon broad interagency planning and response strategies and upon cooperative partnerships between the federal, state, and local governments, as well as private organizations.
2. Achieving and maintaining a high level of resident and visitor preparedness and community resiliency reduces both the negative impact of an emergency and the immediate demands on partner agencies in the region. This level of preparedness and resiliency requires continuous public awareness and education programs.
3. Timely detection of an emerging public health threat relies upon prompt and accurate reporting by healthcare providers, laboratories, and other entities. It may be several days before an emerging threat is recognized as such. Hostile, manmade, and naturally occurring health threats may initially be indistinguishable.
4. The RPHEA may be activated by events that affect the region or another region in New Hampshire, or potentially by events which occur in other states.
5. Activation of a response facility requires a declaration of a public health incident declared by the Commissioner of the DHHS; declaration of a state of emergency declared by the Governor of the

[28] External link: http://my.doe.nh.gov/profiles/sau.aspx.
[29] External link: https://my.doe.nh.gov/Profiles/PublicReports/PublicReports.aspx?ReportName=SchoolsNonPublicByTown.
[30] External link: https://www.dhhs.nh.gov/oos/cclu/.

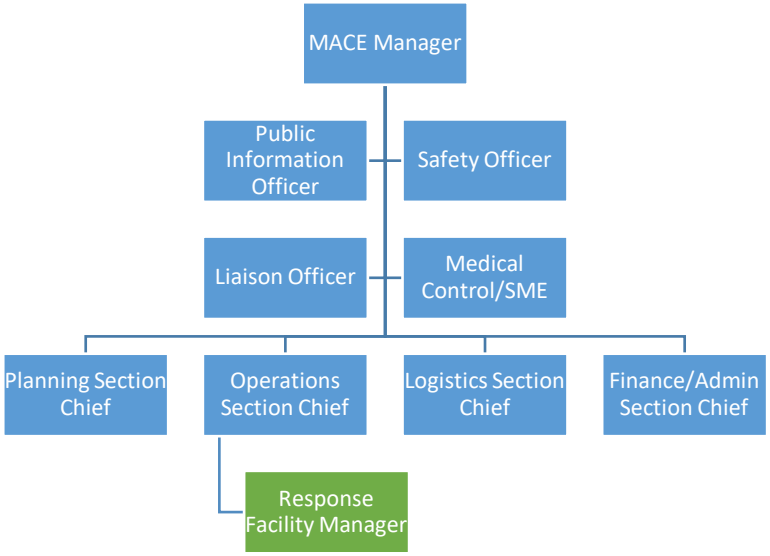
State of New Hampshire; declaration of a federal public health emergency; or declaration of a national emergency by the President of the United States.

6. Public health emergencies are managed at the most local level possible.
7. A public health emergency may overwhelm a jurisdiction's healthcare and public health resources, particularly in rural areas with limited healthcare infrastructure. In such circumstances, coordination is key to effective response.
8. A variety of circumstances or vulnerabilities may affect the ability of local partner agencies to provide services during an emergency. Public health services and routine community activities may be reduced or temporarily discontinued in accordance with continuity of operations plans. Normal governmental business procedures, including financial operations, may require modification to provide essential resources and services while meeting regulatory and accountability requirements.
9. Personnel and resources, including medical and nonmedical countermeasures, may not be available in sufficient supply to completely and immediately address emergency needs.
10. The DHHS may establish populations targeted for early vaccination based on federal recommendations and specific needs in New Hampshire. Vaccine targeting is generally used in situations where demand exceeds supply or to establish an ordered method for dispensing to many people based on epidemiological findings.
11. Lifesaving and health protecting actions, including responder safety and health, take precedence over all other response activities.
12. Whenever possible, evidence-based decision making will be used to direct emergency response and recovery activities. However, some public health emergencies may require that urgent response decisions be made in the absence of complete data.
13. Risk communication is a key component of the public health response.
14. Federal and state laws may be waived or modified in the event of an emergency.

5 CONCEPT OF OPERATIONS

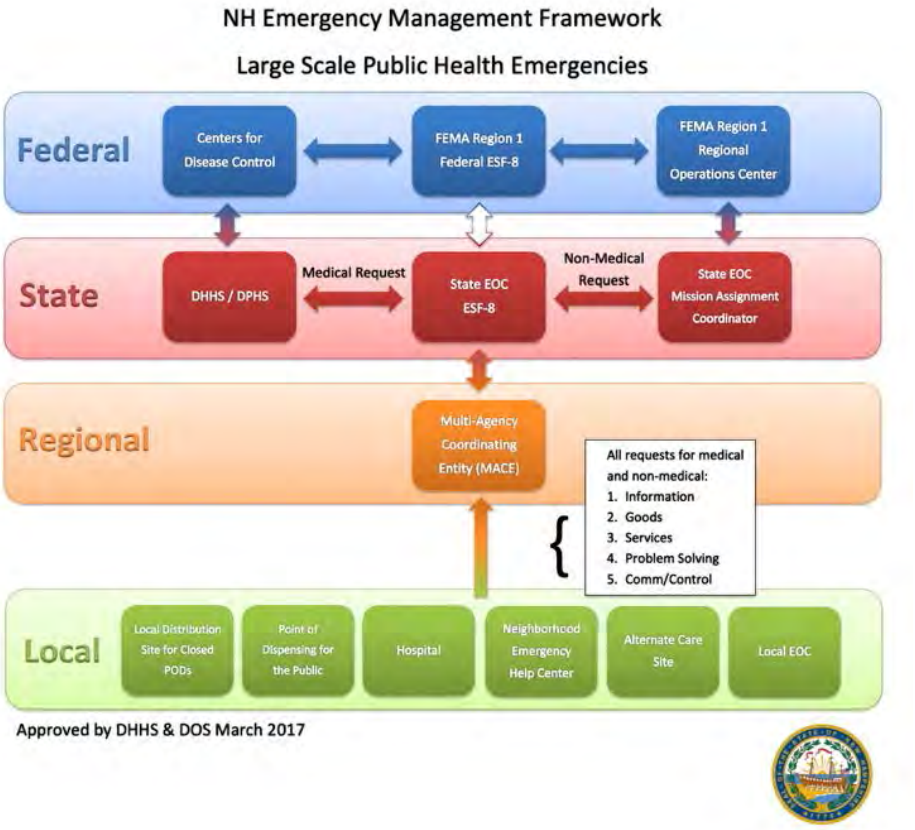
5.1 PUBLIC HEALTH EMERGENCY RESPONSE FRAMEWORK

The MACE manages regional public health emergency operations in coordination with Local Emergency Operations Centers (LEOCs) and public health response facilities (when activated). The MACE consists of representatives from partner agencies and coordinates public health information, staff, and resources during a public health emergency. The LEOC manages local response operations in coordination with the Management Team at each public health response facility (e.g., POD, Neighborhood Emergency Help Center (NEHC), Alternate Care Site (ACS), shelters) and the MACE.



When the State Emergency Operations Center (SEOC) is activated, the DHHS staff are assigned to ESF-8: Public Health and Medical Services. The SEOC, ESF-8 coordinates with the regional MACE to support local public health response operations and to address resource deficiencies.

State and federal partner agencies supplement local and regional resources when they are deemed insufficient to meet the response requirements. The following response framework is used in New Hampshire during large-scale public health emergencies or incidents.



5.2 Emergency & Incident Declaration

Emergency and incident declarations may be put in place to facilitate emergency response.

See also:
NH Statutes with Implications for Public Health Emergency Response Attachment

5.2.1 State of Emergency Declaration

Under RSA 4:45↗[31], the Governor of the State of New Hampshire can declare a State of Emergency in the event of an imminent or occurring natural, technological, or man-made disaster of major proportions. Declaration of a State of Emergency allows the Governor to exercise additional emergency powers, including assuming control of emergency management and helpers in the state; obtaining materials or services; and compelling the evacuation of populations in a threatened area of the state.

5.2.2 State Public Health Incident Declaration

Under RSA 508:17-a↗[32], the Commissioner of the DHHS may declare a Public Health Incident to protect public health and safety when response activities require assistance from non-state agencies. A public health incident declaration may be used when the event does not rise to the level of an emergency declaration by the Governor of the State of New Hampshire.

5.2.3 Federal Public Health Emergency Declaration

Under section 319 of the Public Health Service Act, the Secretary of the Department of Health and Human Services (HHS) may declare a Federal Public Health Emergency↗[33] in response to significant outbreaks of infectious disease or bioterrorism attacks.

5.3 Public Health Response Phases

The RPHEA is a modular, capability-based plan that is organized by response phases. Each partner agency is responsible for maintaining situational awareness and sharing information about potential public health threats and emergencies. Response plans and task lists have been developed to support activation, operations, and demobilization of public health emergency services and activities.

See also:
Activation Appendix & Activation Task List Attachment
Operations Appendix & Operations Task List Attachment
Demobilization Appendix & Demobilization Task List Attachment

[31] External link: http://www.gencourt.state.nh.us/rsa/html/I/4/4-45.htm.
[32] External link: http://www.gencourt.state.nh.us/rsa/html/lii/508/508-17-a.htm.
[33] External link: https://www.phe.gov/Preparedness/legal/Pages/phedeclaration.aspx.

5.4 Public Health Operations Coordination

During a public health emergency in the region, the MACE coordinates public information, as well as staff and resources, to support local public health response facilities.

5.4.1 Public Information Coordination

The MACE Public Information Officer (PIO) may establish a Joint Information Center (JIC) with PIOs from partner agencies to coordinate public information and warning.

5.4.2 Staff & Volunteer Coordination

The MACE coordinates staff and volunteers from partner agencies to support public health emergency services at local response facilities.

5.4.3 Resource Coordination

The MACE coordinates regional and partner agency resources and their distribution to local response facilities.

5.5 Response Facilities

In collaboration with local officials, the North Country PHN has designated local response facilities for specific public health capabilities. Each response facility serves a designated catchment area within the region. Should these facilities not meet the requirements of the emergency, the RPHEA can be used to establish public health operations at a back-up or alternate facility. When selecting an alternate facility, ensure that it is:

- Appropriately sized
- Easily secured
- Accessible to individuals with access and functional needs

See also:
Response Facility Operational Plan Attachments

5.5.1 Strategic National Stockpile (SNS)

The Strategic National Stockpile↗[34] is a federal inventory of medications, antidotes, medical supplies, and medical equipment. SNS resources are deployed to the state when local and state resources are insufficient. SNS resources are managed by the Centers for Disease Control and Prevention (CDC) and support response to a range of emergencies, including acts of terrorism, natural disasters, and industrial accidents.

At the regional level, the MACE Manager and MACE Logistics Section Chief coordinate with the SEOC, ESF-8 to determine if local and state resources are sufficient. If they are insufficient, the SEOC, ESF-8 may recommend requesting SNS resources.

The Governor of the State of New Hampshire (or their designee) requests the SNS resources through the CDC or the US Department of Homeland Security (DHS). Federal officials review the request, determine if the SNS resources are needed, and authorize their deployment. The MACE Manager and the MACE Logistics Section Chief may request that ESF-8 request SNS resources if supplies available within the

[34] External link: https://www.cdc.gov/phpr/stockpile/.

state are insufficient. If SNS resources will be deployed, the SEOC, ESF-8 activates the Receive, Stage, and Store (RSS) facility to receive and repackage resources for distribution to local response facilities. The RSS plan is maintained by the state SNS Coordinator. The public health emergency preparedness program coordinator serves as the regional SNS Coordinator for the North Country PHN and the Public Health Director serves as the back-up regional SNS Coordinator.

Table 16: Regional SNS Coordinator Contact Information

Regional SNS Coordinators	Phone	Email
Primary Contact: **Nicole Woods**	Business Hours: 603.259.4816 After Hours: 603.667-8785	nwoods@nchcnh.org
Back-up Contact: **Jack Anderson**	Business Hours: 603.448.8331 After Hours: 603.448.8331	firechief@bethlehemnh.org

5.5.2 Receive, Stage & Store (RSS)

The RSS is a state warehouse that receives the SNS resources and stages them for repackaging and rapid distribution to local response facilities. The DHHS Emergency Services Unit (ESU) develops and maintains the RSS plan. In situations where the SNS resources are deployed to the state, the SEOC, ESF-8 activates the RSS and mobilizes RSS staff and volunteers. The RSS coordinates with the New Hampshire National Guard to distribute the SNS resources to local response facilities. Depending on incident-specific security requirements, the National Guard may be escorted by the New Hampshire State Police when distributing the SNS resources. If a state police escort is used, the SEOC, ESF-8 notifies the MACE Manager to coordinate with local law enforcement for an escort from the town line to the response facility.

5.5.3 Point of Dispensing (POD)

The POD is a response facility that is used to dispense medical countermeasures (e.g., vaccines, antibiotics, etc.) to the at-risk population. The POD may be activated to respond to:

- Exposure to infectious diseases and infectious disease outbreaks
- Acts of bioterrorism
- A disease outbreak resulting from natural disasters

The POD does not provide extensive medical evaluation, medical treatment, or other services typically provided by a healthcare facility.

When the POD is activated, the DHHS issues medical standing orders for vaccine administration, medication dispensing, and treatment of post-dispensing reactions. Staff and volunteers who are authorized to dispense medical countermeasures adhere to the medical standing orders. At the time of the incident, the State may expand the types of healthcare practitioners who can dispense medical countermeasures at the POD. Additionally, the DHHS may authorize non-medical staff and volunteers to dispense under the supervision of a healthcare practitioner who is authorized to dispense medication.

5.5.4 Neighborhood Emergency Help Center (NEHC)

The NEHC is a response facility that is used to provide information, basic medical evaluation, triage and referral services. The NEHC is a primary point of entry into the community medical surge system for symptomatic and asymptomatic, but potentially exposed, individuals. Specifically, the NEHC is designed to:

- Provide self-help information
- Provide instruction (e.g., home care, medical follow-up, worried well)
- Triage large numbers of people seeking care (e.g., identify those who require hospital-level care)
- Refer low-acuity care patients to the Alternate Care Site (if activated)

5.5.5 Alternate Care Site (ACS)

The ACS is a response facility that is used to provide in-patient, low-acuity medical care in a community-based location. Patients may enter the ACS through referrals from the NEHC, private physicians, or area hospitals. Care at an ACS is limited to supportive care for low-acuity patients who are too ill to self-treat at home and, under normal conditions, may otherwise be admitted to a hospital. This will allow hospitals to conserve staff and resources to focus on the treatment of the most critically ill patients. The ACS provides cares to patients who:

- Need intravenous (IV) hydration
- Need minimal oxygen therapy
- Need oral or IV antibiotics
- Are able to eat and drink on their own
- Can maintain self-sufficiency or are accompanied by a caretaker or family member who can assist with care

The ACS may also provide temporary morgue services to support fatality management operations during an incident (naturally occurring mass fatalities only).

5.5.6 Mass Care Shelter

Municipal emergency management is responsible for mass care and emergency shelter activation and operations. The MACE may coordinate staff and resources to support public health roles at a mass care shelters (e.g., FNSS, infection control, infectious disease surveillance, behavioral health, environmental health, etc.).

5.5.7 Regional Response Facility Locations

The following table lists the designated response facilities in the PHR. The PHN has an MOU with each of these facilities.

Table 17: Designated Public Health Response Facilities

Response Facility	Catchment Area	Capabilities
Berlin High School 550 Willard St. Berlin, NH 03570	Berlin, Gorham, Shelburne, Milan	Primary POD
Colebrook School District 27 Dumont St. Colebrook, NH 03576	Colebrook, Pittsburg, Stewartstown, Clarksville, Columbia	Primary POD
Haverhill Middle School 175 Morrill Drive North Haverhill, NH 03774	Haverhill, Landaff, Lisbon, Bath, Benton	Primary POD, Neighborhood Emergency Help Center

Response Facility	Catchment Area	Capabilities
Lafayette Regional School 149 Main Street, Franconia, NH 03580	Franconia, Sugar Hill, Easton, Bethlethem	Primary POD 2
Lancaster Elementary School 51 Bridge St. Lancaster, NH 03584	Lancaster, Northumberland, Whitefield, Kilkenny	Primary POD, Neighborhood Emergency Help Center
Littleton High School 159 Oak Hill Ave. Littleton, NH 03561	Littleton, Dalton	Primary POD
Profile Middle/High School 691 Profile Road Bethlehem, NH 03574	Bethlehem, Franconia, Sugar Hill	Primary POD
Daughters of the Charity of the Sacred Heart of Jesus 226 Grove St, Littleton, NH 03561	Littleton, Haverhill	Alternate Care Site
Indian Stream Health Center 141 Corliss Ln, Colebrook, NH 03576	Colebrook, Stewartstown, Pittsburg, Columbia	Alternate Care Site
White Mountain Regional High School 127 Regional Rd, Whitefield, NH 03598	Lancaster, Whitefield, Jefferson, Northumberland	Alternate Care Site
Coos County Family Health Services 133 Pleasant St. Berlin, NH 03570	Berlin, Gorham, Shelburne, Dummer, Milan	Neighborhood Emergency Help Center

5.5.8 Closed PODs

Closed PODs are businesses or organizations that have the ability to dispense medical countermeasures to a defined population (e.g., staff, staff families, residents), as opposed to the general public.

The following table lists Closed POD sites within the PHR. The PHN has an MOU with each of these facilities.

Table 18: Designated Closed PODs

Closed POD Facilities	Facility Address
Country Village	**91 Country Village Road Lancaster, NH 03584**
Lafayette Center	**93 Main St, Franconia, NH 03580**
Grafton County Nursing Home	**3855 Dartmouth College Highway, N. Haverhill, NH 03774**
BERLIN AREA	
St. Vincent de Paul	**29 Providence Avenue, Berlin, NH 03570**
Androscoggin Valley Hospital	**59 Page Hill Road, Berlin, NH 03570**
Coos County Nursing Home	**364 Cates Hill Road, Berlin, NH 03570**

5.6 Health Threat Identification & Assessment

Federal and state health officials maintain systems for routine monitoring of unusual disease patterns. Once a health threat has been identified and characterized, federal and state health authorities will:

- Recommend appropriate protective actions and control measures
- Assess the need to activate the public health emergency response framework
- Determine if local and state resources are sufficient to support response activities

Throughout response, the MACE will consult with regional, state, and federal subject matter experts (SMEs) to develop a response strategy for a particular incident and inform incident management decision making. If a regional SME cannot be identified, the MACE will work with the SEOC, ESF-8 to identify an appropriate state or federal SME. Types of SMEs required may include: chemical, biological, radiological, nuclear, and explosive (CBRNE); environmental/natural hazards; epidemiology; immunizations; laboratory; medical/medical countermeasures (MCM); security; RSS/inventory management/warehouse logistics; and transportation.

See also:
Information Collection, Analysis & Dissemination↓↑

5.6.1 Public Health Impact

Once a health threat is identified, federal and state health officials determine its potential impact on public health. SMEs review the available data and recommend control measures. Depending on the nature of the incident and the recommended response, the DHHS may recommend activation of the MACE to coordinate regional response activities and support local public health response operations.

5.6.2 Public Health Roles

At the time of the emergency, state and local partner agencies will determine whether public health has a lead role, supporting role, or no role. A request for MACE activation may occur to support response operations for which public health has a lead or supporting role.

5.6.2.1 Lead Role

Public health has primary responsibility to establish incident response objectives and to assign tasks to supporting agencies. Examples include outbreaks of meningitis, hepatitis, and influenza.

5.6.2.2 Supporting Role

Public health is assigned tasks by the LEOC or SEOC. Examples include natural disasters, weather events, and industrial accidents.

5.6.2.3 No Role

There is no public health implication, protective action, or control measure.

5.7 Control Measure Selection

State and local partner agencies may request activation of the MACE to coordinate implementation of protective actions and public health control measures in the region. Examples of control measures include (but are not limited to):

- Medical countermeasure dispensing

- Isolation and quarantine
- Community containment measures (e.g., cancelation of events, school closures, social distancing)
- Public information and warning

NH DHHS, Division of Public Health Services (DPHS) SMEs will consult with the MACE regarding the implementation of selected control measures.

6 Organization & Responsibilities

The RPHEA outlines roles and responsibilities assigned to specific partner agencies and to designated positions within the regional MACE and at local public health response facilities.

7 Information Collection, Analysis & Dissemination

Table 19: Information Collection Systems

System Name	Manager	Geography	Type of Info	Dissemination Mechanism
Automated Hospital Emergency Department Data (AHEDD)	Bureau of Infectious Disease Control (BIDC)	Statewide	Real-time Emergency Department (ED) data for chief complaints and International Classification of Diseases (ICD) codes)	Weekly Early Event Detection (WEED) report
BioSense	CDC	National	Biosurveillance from Veterans Administration (VA) hospitals and Department of Defense (DOD) healthcare systems across the country	WEED report
Death certificate surveillance database	Division of Vital Records Administration (DVRA)	Statewide	Deaths associated with pneumonia, influenza, communicable diseases, and other potential public health threats	WEED report
Real-time Outbreak and Disease Surveillance (RODS)	University of Pittsburgh	Statewide	Over-the-Counter (OTC) pharmaceutical sales	WEED report
School surveillance	BIDC	Statewide	Daily aggregate data for student and staff absenteeism, those absent for Influenza-like illness (ILI), total school nurse visits, and nurse visits for ILI	NH School Absenteeism Report by County↗[35] and WEED report
Seasonal surveillance	BIDC	Statewide	Seasonal health data, including allergen levels, carbon monoxide exposures, and heat- and cold-related injuries	WEED report

[35] External link: https://www.dhhs.nh.gov/dphs/cdcs/influenza/schoolsurveillance.htm.

System Name	Manager	Geography	Type of Info	Dissemination Mechanism
Syndromic Tracking Encounter Management System (STEMS)	BIDC	Statewide	OTC pharmaceutical sales	WEED report
Arbovirus surveillance	BIDC	Statewide	Human, animal, and mosquito test results for West Nile Virus (WNV) and Eastern Equine Encephalitis (EEE)	Weekly Arbovirus Surveillance Bulletin↗[36]
Influenza Surveillance		Statewide	Respiratory specimens for influenza testing	Weekly Influenza Surveillance Report↗[37] (October – mid-May)

See also:
NH DPHS, Bioterrorism Surveillance Program↗[38]
NH DPHS, BIDC↗[39]
NH DVRA↗[40]

8 COMMUNICATIONS

Communications between responding partner agencies follow the Public Health Emergency Response Framework↓↑. To develop and maintain a common operating picture, responding agencies will access and use communication platforms including the Health Alert Network (HAN), WebEOC, Knowledge Center, and E-Studio.

The DHHS PIO, along with DHHS SMEs, develop and coordinate clinical guidance and information on the public health threat and the recommended protective actions. The MACE PIO/PIOs from the responding partner agencies develop and coordinate information related to local emergency public health services in response to the threat. The MACE PIO may establish a JIC to support public information and warning activities. Policies and procedures for establishing a JIC, tactical communications, public information and warning, and functional needs communications are found in the Appendices and Task Lists.

The following tables document communication platforms that can be used to communicate directly to the public and local media contacts.

Table 20: Public Information & Warning Communication Platforms

Agency	Platform	Population
Grafton County Dispatch	Red Alert	Subscribers for Grafton County, Businesses and Residents
North Country Health Consortium	Website/Facebook	General population for Northern Grafton and Coos Counties

[36] External link: https://www.dhhs.nh.gov/dphs/cdcs/arboviral/results.htm.
[37] External link: https://www.dhhs.nh.gov/dphs/cdcs/influenza/activity.htm.
[38] External link: https://www.dhhs.nh.gov/dphs/cdcs/surveillance/bioterrorism.htm.
[39] External link: https://www.dhhs.nh.gov/dphs/cdcs/index.htm.
[40] External link: http://sos.nh.gov/vital_records.aspx.

Table 21: State and Local Media Contacts

Media Name	Media Type	Contact/Phone/Fax/Email
Berlin Sun	Weekly Newspaper (Thursday)	**Contact Name:** Barbara Tetreault (Editor) **Phone:** (603) 752-5858/ **Fax:** n/a **Email:** bds@berlindailysun.com
Berlin Reporter Coos Democrat	Weekly Newspaper (Wednesday)	**Contact Name:** Tara Giles (Editor) **Phone:** (603) 752-1200/ **Fax:** 603-788-3022 **Email:** tara@salmonpress.news
Littelton Courier	Weekly Newspaper (Wednesday)	**Contact Name:** Tara Giles (Editor) **Phone:** (603) 279-4516/ **Fax:** 603-279-3331 **Email:** tara@salmonpress.news
Colebrook Chronicle	Weekly Newspaper (Friday)	**Contact Name:** Charles Jordan (Editor) **Phone:** (603)246-8998 /**Fax:** (603)246-9918 **Email:** editor@colebrookchronicle.com
The News and Sentinel Colebrook	Weekly Newspaper (Wednesday)	**Contact Name:** Karen Harrigan (Editor) **Phone:** 603 237 5501/**Fax:** 603 237 5060 **Email:** editor@colebrooknewsandsentinel.com
North Woods Weekly	Weekly Newspaper (Friday)	**Contact Name:** Karen Ladd (Editor/Publisher) **Phone:** 603-237-5501 **Fax:** n/a **Email:** editor@northwoodsweekly.com
Caledonian Record	Daily newspaper (M-F + Sat/Sun)	**Contact Name: Dana Gray, Editor** **Phone:** (802)748-8121/ **Fax:** n/a **Email:**news@caledonian-record.com

9 Administration, Finance & Logistics

The MACE coordinates administration, finance, and logistics activities for local public health emergency services. The MACE Finance and Administration Section Chief tracks regional expenditures and staff and volunteer hours associated with the response. The MACE Logistics Section Chief secures necessary response resources, including staff, equipment, and supplies, and then coordinates their deployment to public health response facilities.

The Response Facility Management Team, the LEOC (if activated), and responding partner agencies maintain records of all response-related expenditures and obligations, as well as situation reports. Records and reports are submitted to the MACE to be compiled and submitted to the SEOC, ESF-8.

9.1 Funding & Accounting

The PHN host agency establishes accounting procedures for tracking costs associated with a regional public health response. At the time of the emergency, the DHHS will advise the PHN host agency of funding availability and additional accounting requirements if state or federal reimbursement is anticipated. The PHN host agency provides guidance to partner agencies to ensure that costs are properly documented.

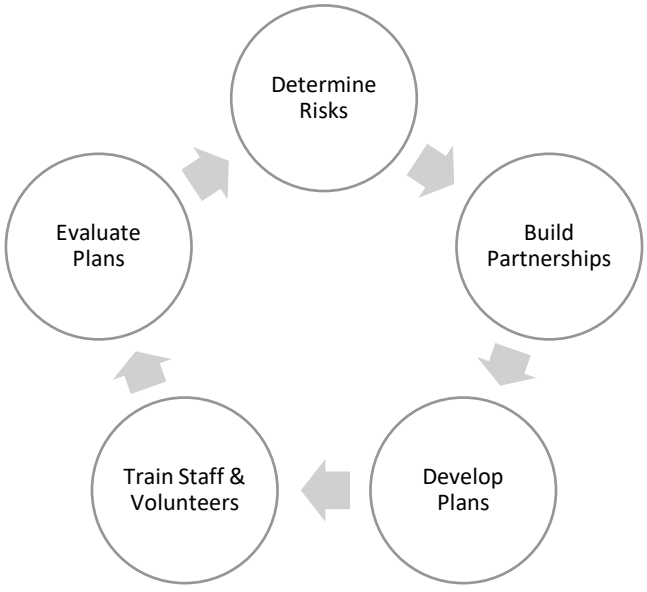
9.2 Agreements & Understandings

The North Country PHN develops MOUs with partner agencies to support regional public health emergency services. The regional PHEP Coordinator and the regional coordinating commitee review existing MOU annually and develop new agreements as needed. In addition to MOUs for response facilities↓↑ and Closed PODs↓↑, the following list details current MOU and the agreed to capabilities of each (e.g., facility use, staffing, security, transportation, etc.).

Table 22: List of Memoranda of Understanding

Capability	Agency	Physical Location of Resource
Closed POD	Country Village	On file with EMD and PHNC
Closed POD	Lafayette Center	On file with EMD and PHNC
Closed POD	St. Vincent de Paul	On file with EMD and PHNC
Closed POD	Androscoggin Valley Hospital	On file with EMD and PHNC
Closed POD	Coos County Nursing Home	On file with EMD and PHNC
Closed POD	Grafton County Nursing Home	On fine with EMD and PHNC
Open POD	Colebrook School	On file with EMD and PHNC
Open POD	Lancaster Elementary School	On file with EMD and PHNC
Open POD	Berlin High School	On file with EMD and PHNC
Open POD	Littleton High School	On file with EMD and PHNC
Open POD	Profile Middle/High School	On file with EMD and PHNC
Open POD	Haverhill Middle School	On file with EMD and PHNC
Open POD	Lafayette Regional School	On file with EMD and PHNC

Plan Development & Maintenance



9.3 Plan Development

The North Country PHN recruits key stakeholders to participate in the regional coordinating committee . The regional coordinating commitee supports the development and maintenance of plans,

policies, procedures, and systems that support regional public health emergency services. The regional coordinating commitee membership draws from the 11 community sectors[41] designated by the CDC as essential to support public health preparedness and response capabilities.

The comittee meets bi-monthly. The coordinator documents meeting attendance, minutes, and preparedness activities.

The DHHS issues guidance on developing the RPHEA and local public health capabilities.

The comittee considers the following objectives when developing and maintaining the RPHEA:

- Determine regional health risks
- Build partnerships to support public health preparedness
- Develop plans to coordinate staff, resources, and information
- Develop site-specific response facility plans
- Train staff and volunteers on public health response capabilities
- Exercise, evaluate, and improve public health response plans

9.4 Plan Maintenance

The regional PHEP Coordinator maintains the RPHEA for the North Country PHN. The PHEP Coordinator and the commitee reviews the RPHEA annually to identify necessary updates and to consider changes based on lessons learned, evaluations, or model practices. Updates to the RPHEA must be NIMS-compliant and approved by the committee. When updated, the PHEP Coordinator re-distributes the RPHEA to partner agencies with assigned roles and responsibilities.

9.4.1 Review Criteria

When updating the RPHEA, the PHEP Coordinator and the committee consider the following:

- Any new risk assessments
- Changes to the Concept of Operations↓↑
- Changes within partner agencies (e.g., key staff, capabilities, capacity for assigned roles, etc.)
- Changes to warning and communications systems
- Changes to emergency resources (e.g., resource type, acquisition and disposition procedures, etc.)
- Changes to federal and state guidance and requirements
- Changes to existing agreements and understandings↓↑ (or new MOU established)
- Exercise and incident evaluations
- Assessments conducted by federal or state officials (e.g., Medical Countermeasures Operational Readiness Review (MCM-ORR), site evaluation, etc.)
- Proposed updates submitted by partner agencies

[41] The CDC *Public Health Preparedness Capabilities* identify the following 11 community sectors as essential to community preparedness: business; community leadership; cultural and faith-based organizations; emergency management; healthcare; social services; housing and sheltering; media; mental/behavioral health; elder services; and education and childcare.

9.4.2 Review Process

Partner agencies can propose updates to the RPHEA by submitting proposed updates to the regional PHEP Coordinator. When conducting the annual review of the RPHEA, the regional PHEP Coordinator will:

- Present the proposed updates to the regional coordinating committee
- Obtain approval or denial of the proposed updates
- Update the RPHEA with approved changes
- Note changes to the RPHEA on the Record of Changes
- Distribute updated RPHEA to partner agencies listed on the Record of Distribution

9.4.3 Review Timeline

The regional PHEP Coordinator completes the annual review based on the following timeline:

- March – Review the RPHEA
- April – Submit proposed updates to the commitee for review
- May – Update the RPHEA based on approved changes
- June – Distribute updated RPHEA to partner agencies

9.4.4 Contact Information Updates

All partner agencies, response facility staff, and volunteers are prompted to update their contact information every 6 months or as needed. The North Country PHN confirms contact information through quarterly notification exercises and updates incorrect information. Updated contact information is noted on the Record of Changes and distributed to partner agencies listed on the Record of Distribution.

9.5 TRAINING

The DHHS and the North Country PHN develop and offer competency-based trainings for partner agencies with public health emergency response roles. The North Country PHN develops Just-in-Time Training (JITT) for staff and volunteers working in public health response facilities. The following trainings are recommended for staff and volunteers with public health emergency response roles.

9.5.1 Incident Command System

Staff with roles and responsibilities for emergency public health services should be trained in incident command and emergency management concepts. These competencies are attained by completing NIMS training. Staff are organized into tiers based on their assigned role during an incident. The following table describes each tier and corresponding response role. The RPHEA and its associated response roles are focused on Tier 3 and Tier 4 staff and volunteers.

Table 23: RPHEA Staff (by the CDC tiers)

Staff Tier	Response Role
Tier 1	No specified role (all staff)
Tier 2	LEOC, ESF-8
Tier 3	**Response Facility Management Team**
Tier 4	**Incident management leadership (MACE)**

The following training matrix matches each staff tier to NIMS trainings that will prepare them for their response role.

Table 24: NIMS Training Matrix, RPHEA Staff & Volunteers

Staff Level	IS-100.b	IS-200.b	IS-300	IS-400	IS-700.a	IS-800.b
Tier 1 Staff	X				X	X
Tier 2 Staff	X	X			X	X
Tier 3 Staff (e.g., POD Management Team)	X	X	X		X	X
Tier 4 Staff (e.g., MACE Management Team)	X	X	X	X	X	X

The NIMS Training Matrix includes the following ICS trainings.

- IS-100.b↗[42], Introduction to ICS
- IS-200.b↗[43], ICS for Single Resources & Initial Action Incidents
- IS-300, Intermediate ICS for Expanding Incidents (classroom)
- IS-400, Advanced ICS (classroom)
- IS-700.a↗[44], NIMS, An Introduction
- IS-800.b↗[45], National Response Framework, An Introduction

9.5.2 Emergency Operations Coordination

The following trainings related to public health emergency operations coordination are recommended for tier 3 and tier 4 staff:

- WebEOC (NH Homeland Security and Emergency Management (HSEM))
- Knowledge Center (Healthcare Coalition Administrative Lead Organization (HCC ALO))
- MACE Staff Training

The following optional trainings are recommended for tier 4 staff:

- IS-546.a↗[46], Continuity of Operations (COOP) Awareness
- IS-547.a↗[47], Introduction to COOP
- IS-775↗[48], Emergency Operations Center (EOC) Management & Operations

9.5.3 Public Information & Warning

The following trainings related to public information and warning are recommended for tier 3 and tier 4 staff with communication roles and responsibilities:

- IS-250.a↗[49], ESF-15 Emergency Communication & Information Distribution (required)
- IS-702.a↗[50], NIMS Public Information Systems
- Crisis Emergency Risk Communications↗[51] (CERC)

[42] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-100.b.
[43] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-200.b.
[44] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-700.a.
[45] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-800.b.
[46] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-546.a.
[47] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-547.a.
[48] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-775.
[49] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-250.a.
[50] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-702.a.
[51] External link: https://emergency.cdc.gov/cerc/training/basic/index.asp.

- CERC Infectious Disease Online Training↗[52]
- JIC training
- Social Media in Emergencies

9.5.4 Medical Countermeasure Dispensing

The following trainings related to medical countermeasure dispensing are recommended for tier 3 staff, tier 4 staff, and volunteers:

- NH POD Training
  - Module 1: Strategic National Stockpile
  - Module 2: Countermeasure Dispensing
  - Module 3: Point of Dispensing

9.5.5 Resource Management & Distribution

The following trainings related to resource management and distribution are recommended for tier 4 staff with resource management and distribution responsibilities:

- IS-808↗[53], ESF-8 – Public Health and Medical Services
- Integrated Resource Management System (IRMS) training (DHHS ESU)
- Vaccine Ordering Management System (VOMS) training (New Hampshire Immunization Program (NHIP))

9.5.6 Staff & Volunteer Management

The DHHS and the North Country MRC collaborate to offer statewide and regional volunteer training programs. The North Country MRC establishes training requirements for volunteers who wish to participate in emergency response activities.

The following trainings related to staff and volunteer management capability are recommended for tier 3 and tier 4 staff with staff and volunteer management roles:

- IS-244.b↗[54], Developing and Managing Volunteers

9.6 Exercises & Evaluation

The regional PHEP Coordinator collaborates with federal, state, and local partner agencies to conduct exercises and complete evaluations of the RPHEA. These exercises and evaluations are used to identify strengths and areas for improvement planning.

9.6.1 Homeland Security Exercise & Evaluation Program

The Homeland Security Exercise and Evaluation Program (HSEEP) provides the framework for exercise design, management, evaluation, and improvement planning. The focus of the regional exercises should be consistent with the most current state PHEP deliverables. The regional PHEP Coordinator is required to be HSEEP-certified and should also complete the following exercise trainings:

[52] External link: https://emergency.cdc.gov/cerc/training/panflu/index.asp.
[53] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-808.
[54] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-244.b.

- IS-120.a[55], An Introduction to Exercises
- IS-130[56], Exercise Evaluation and Improvement Planning

9.6.2 Medical Countermeasure Operational Readiness Review

CDC developed the MCM-ORR to evaluate jurisdictional readiness for medical countermeasure dispensing and other associated public health preparedness capabilities. CDC and DHHS conduct periodic evaluations (or as required) of regional planning and operational implementation for medical countermeasure dispensing. Results from these evaluations are used to improve response capabilities, identify training needs, and plan for drills and exercises.

10 AUTHORITIES & REFERENCES

10.1 AUTHORITIES

Authority for mitigation, preparedness, response, and recovery activities for public health emergencies and incidents are described below.

10.1.1 Federal Authority

The HHS is the lead federal agency for mitigation, preparedness, response, and recovery activities related to public health threats. The CDC manages public health response operations within HHS. The CDC Division of Strategic National Stockpile (DSNS) coordinates medical material management and distribution from the SNS[57]. The Assistant Secretary for Preparedness and Response (ASPR) manages healthcare system response operations within HHS. The ASPR builds federal medical surge capacities through the National Disaster Medical System (NDMS) to augment state and local capabilities during an emergency or disaster.

Relevant Federal Laws, Executive Orders, and Homeland Security Presidential Directives include:

- Homeland Security Presidential Directive (HSPD) 3, “Homeland Security Advisory System,” March 11, 2002
- Homeland Security Presidential Directive (HSPD) 5, “Management of Domestic Incidents,” February 28, 2003
- Homeland Security Presidential Directive (HSPD) 8, “National Preparedness,” December 17, 2003
- The Federal Civil Defense Act of 1950, as amended, provides a system for joint building of capability at the federal, state, and local levels to deal with all hazards.
- The Food Stamp Act of 1964, in conjunction with Section 412 of the Stafford Act, relating to food stamp distribution after a major disaster.
- The Disaster Relief Act of 1974, as amended, which provides authority for response assistance under the National Response Framework and which empowers the President to direct any Federal agency to use its authority and resources in support of state and local assistance efforts.

[55] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-120.a.
[56] External link: https://training.fema.gov/is/courseoverview.aspx?code=IS-130.
[57] External link: https://www.cdc.gov/phpr/stockpile/.

- The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) as amended, which requires facilities to notify authorities of accidental releases of hazardous materials.
- The Superfund Amendments and Reauthorization Act of 1986, which governs hazardous materials planning and right-to-know.
- The Emergency Medical Treatment & Labor Act (EMTALA) of 1986 which requires public access to emergency services regardless of ability to pay.
- The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 ("Stafford Act"), which amends the Disaster Relief Act of 1974 and constitutes the statutory authority for most Federal disaster response activities especially as they pertain to FEMA and FEMA programs
- The Americans with Disabilities Act of 1990, which prohibits discrimination against people with disabilities in several areas, including employment, transportation, public accommodations, communications and access to state and local government' programs and services.
- The Emergency Management Assistance Compact of 1996, which provides the framework for mutual assistance between the interstate mutual aid in governor-declared emergencies.
- The Disaster Mitigation Act of 2000, which amends the Stafford Act and provides the legal basis for FEMA's mitigation plan requirements for local, state, and tribal mitigation plans as a condition of mitigation grant assistance.
- The Public Readiness and Emergency Preparedness (PREP) Act of 2005 provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of disaster countermeasures.
- The Pets Evacuation and Transportation Standards (PETS) Act of 2006, which amends the Stafford Act to require states seeking FEMA assistance to include provision for pets and service animals in evacuation planning.
- The Post-Katrina Emergency Management Reform Act of 2006, which establishes planning and response guidelines to meet the needs of people with functional needs and others impacted by disaster.
- Pandemic and All Hazards Preparedness Act (PAHPA) of 2006, which amended the Public Health Service Act, established the ASPR, advanced development and acquisitions of medical countermeasures; and a quadrennial National Health Security Strategy.
- Stewart B. McKinney Homeless Assistance Act of 1987, which authorizes the Federal Emergency Management Food and Shelter Program.
- Nuclear Regulation (NUREG) 0654/FEMA-REP-1, which provides federal guidance for development and review of Radiological Emergency Management Plans for nuclear power plants.

10.1.2 State Authority

The DHHS is the lead state agency for ESF-6 (Mass Care) and ESF-8 (Health and Medical), which includes mitigation, preparedness, response, and recovery activities related to public health threats. The ESU staffs the SEOC ESF-8 desk during emergencies. SEOC, ESF-8 coordinates with the regional MACE to support regional public health response operations and to address resource deficiencies.

State laws relevant to public health emergency response include:

- RSA 21-P:37 and 53↗[58], Department of Safety, which establishes authorities of the Governor, including the ability to take "direct operations control" in emergencies, and the Commissioner of DHHS to carry out public health response activities.
- RSA 541-A:18↗[59], Administrative Procedure Act, which enables state agencies to adopt emergency rules in emergencies.
- RSA 4:45-47↗[60], Powers of the Governor and Council In Certain Cases, which allows the Governor to declare a State of Emergency and exercise emergency management powers. RSA 108:3↗[61], Emergency Management Assistance Compact and Northeastern American/Canadian Emergency Management Assistance Compact, which enables the Governor to access mutual aid in Governor-declared States of Emergency.

10.1.3 Regional Authority

North Country Health Consortium has been designated by the DHHS as the lead coordinating agency in the North Country PHR for mitigation, preparedness, response, and recovery activities related to public health threats. The North Country PHN convenes partner agencies to develop plans, policies, procedures, and systems used in public health response operations. The MACE manages regional public health emergency operations in coordination with Local Emergency Operation Centers (LEOCs) and public health response facilities (if activated). The MACE consists of representatives from partner agencies and coordinates public health information, staff, and resources during an incident.

10.1.4 Local Authority

Under RSA 21-P:39↗[62] and RSA 128↗[63], each town in the North Country PHR appoints a local EMD and Health Officer (HO). The EMD for each town maintains a LEOP. The LEOP should help support emergency public health services at local response facilities in coordination with the regional MACE. The RPHEA is intended to be an annex to the LEOP.

The sections below provide an overview of laws that regulate public health protective actions as the local level and provide local authority for public health emergency actions.

10.1.4.1 Communicable Disease Reporting

Under RSA 141-C:7↗[64], the DHHS conducts statewide communicable disease surveillance activities, including case investigations and laboratory testing. Local and regional disease surveillance relies on reports from healthcare providers and schools to the DPHS, BIDC. The DPHS, Public Health Laboratories↗[65] (PHL) conducts testing of biological and environmental samples. The PHL has established guidelines for specimen collection, packaging, and transport.

See also:
NH Reportable Diseases & Reporting Guidelines↗[66]

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[58] External link: http://www.gencourt.state.nh.us/rsa/html/i/21-p/21-p-mrg.htm.
[59] External link: http://www.gencourt.state.nh.us/rsa/html/LV/541-A/541-A-18.htm.
[60] External link: http://www.gencourt.state.nh.us/rsa/html/i/4/4-mrg.htm.
[61] External link: http://www.gencourt.state.nh.us/rsa/html/VIII/108/108-mrg.htm.
[62] External link: http://gencourt.state.nh.us/rsa/html/I/21-P/21-P-39.htm.
[63] External link: http://www.gencourt.state.nh.us/rsa/html/x/128/128-mrg.htm.
[64] External link: http://www.gencourt.state.nh.us/rsa/html/X/141-C/141-C-7.htm.
[65] External link: https://www.dhhs.nh.gov/dphs/lab/index.htm.
[66] External link: https://www.dhhs.nh.gov/dphs/cdcs/documents/reportablediseases.pdf.

NH Laboratory Testing Menu[67]
NH Influenza Test Requisition Form[68]

10.1.4.2 Isolation & Quarantine

Under RSA 141-C:11[69], the DHHS Commissioner establishes isolation and quarantine measures to reduce the spread of disease. Emphasis is placed on the least restrictive means (i.e., voluntary quarantine). However, under RSA 141-C:12[70], the DHHS Commissioner can issue a written order for isolation and quarantine, if needed. Non-compliance with an isolation or quarantine order may lead to a complaint to the court and may result in the individual being taken into custody.

Under RSA 141-C:5[71], local HOs can assist the DHHS Commissioner to establish and maintain isolation and quarantine orders to prevent and control the spread of communicable diseases. Local officials should consider the essential daily living needs of individuals and dependents that are isolated or quarantined in their homes (e.g., medications, food, water, and other resources).

Under RSA 141-C:15[72], the DHHS Commissioner can require individuals under isolation and quarantine to receive treatment. If an individual refuses or is non-compliant with their treatment, the DHHS Commissioner may obtain a court order. Under RSA 141-C:15, if an individual under isolation or quarantine is non-compliant with orders for treatment, local law enforcement may be called upon to take the individual into custody.

If isolation at home or in an ACS is not possible, then individuals should be admitted to a hospital or healthcare facility (if clinical conditions warrant). Personal Protective Equipment (PPE) should be used when isolating individuals in accordance with guidance issued by state and federal health officials at the time of the event.

10.1.4.3 Liability and Workers' Compensation

NH Law provides several mechanisms for liability and workers' compensation coverage for volunteers in emergency response.

RSA 21-P:41[73], Immunity and Exemption, provides liability and workers' compensation for workers "performing emergency management services at any place in this state pursuant to agreements, compacts or arrangements for mutual aid and assistance, to which the state or one of its political subdivisions is a party." It states that, "if the worker is not an employee of the state or one of its political subdivisions, [he/she will] be entitled to the same rights as to compensation for injuries as are provided by law for the employees of this state. The emergency management personnel shall, while on duty, be subject to the operational control of the authority in charge of emergency management activities in the area in which they are serving."

[67] External link: https://www.dhhs.nh.gov/dphs/lab/documents/testmenu.pdf.
[68] External link: https://www.dhhs.nh.gov/dphs/lab/documents/influenzatestform.pdf.
[69] External link: http://www.gencourt.state.nh.us/rsa/html/X/141-C/141-C-11.htm.
[70] External link: http://www.gencourt.state.nh.us/rsa/html/X/141-C/141-C-12.htm.
[71] External link: http://www.gencourt.state.nh.us/RSA/html/X/141-C/141-C-5.htm.
[72] External link: http://www.gencourt.state.nh.us/rsa/html/X/141-C/141-C-15.htm.
[73] External link: http://www.gencourt.state.nh.us/rsa/html/I/21-P/21-P-41.htm.

Under RSA 508:17-a[74], the DHHS Commissioner and the Department of Safety (DOS) Commissioner are authorized to declare a public health or a public safety incident, respectively. A public health or public safety incident is one that requires the assistance of individuals, referred to as "agents" in the statute, from outside of the state system. These agents assist with response to the incident, but are not compensated by the state (beyond reimbursable expenses). After being enrolled as an agent of the state, individuals are protected from claims and civil actions arising from acts committed within the scope of their official duties. The statute also provides for workers' compensation coverage for enrolled agents. These liability protections are only in effect when:

- The Commissioner declares a public health or public safety incident;
- The Commissioner specifically designates a person as an agent of state;
- The agent acts in good faith and within the scope of their official duties; and
- The damage or injury was not caused by willful, wanton, or grossly negligent misconduct.

No disciplinary action may be taken by a licensing board against a licensee who is acting as an agent of the state if the above requirements were met.

Finally, RSA 281-A:2[75] Workers' Compensation provides workers' compensation coverage for emergency volunteers provided that the volunteer in a Citizens Corps local council program activated by authorized political subdivision employee eligible for workers compensation and is an agents of the state (see above discussion of RSA 508:17-a) in a public health or public safety incident eligible for workers' compensation.

See also:
Agent of State Form Attachment
NH Statutes with Implications for Public Health Emergency Response Attachment

10.2 References

10.2.1 Public Health Preparedness Capabilities

The Public Health Preparedness Capabilities[76] were developed by the CDC as national standards for state and local public health preparedness. Where appropriate (based on authority and the Public Health Emergency Response Framework), these capabilities are integrated in the RPHEA and its Appendices, Attachments, and Task Lists.

10.2.2 Comprehensive Preparedness Guide

The Comprehensive Preparedness Guide[77] (CPG) 101 was developed by the FEMA to provide guidance on planning and developing emergency operations plans, including format and structure. The RPHEA

[74] External link: http://www.gencourt.state.nh.us/rsa/html/LII/508/508-17-a.htm.
[75] External link: http://gencourt.state.nh.us/rsa/html/XXIII/281-A/281-A-2.htm.
[76] External link: https://www.cdc.gov/phpr/readiness/capabilities.htm.
[77] External link: https://www.fema.gov/media-library-data/20130726-1828-25045-0014/cpg_101_comprehensive_preparedness_guide_developing_and_maintaining_emergency_operations_plans_2010.pdf.

and its operational phase Appendices, Attachments, and Task Lists were developed using these guidelines.

11 SIGNATURE OF ACCEPTANCE

The following agencies acknowledge their roles and responsibilities as outlined in the RPHEA and any associated agreements. Their signature acknowledges receipt of the RPHEA and an agreement to participate in planning, training, and exercise activities. The RPHEA takes effect on 10/1/19. The Signature of Acceptance will be renewed every two years or if a significant change occurs to the outlined roles and responsibilities or authorized agency personnel.

James Watkins, Fire Chief
[Name, Title] Berlin EMS
[Town or Agency]
1/8/20
[Date]

Chief — Littleton Fire Rescue — Fire Chief/EMD
[Name, Title]
[Town or Agency]
[Date]

Chris Jack Stackhouse — EMD Bethlehem Chief Jack Anderson — 03/06/20
[Name, Title]
[Town or Agency]
[Date]

Philip Cloutier — Fire Chief
[Name, Title] Philip Cloutier
[Town or Agency] Gorham Fire/EMS
1/8/20
[Date]

Mark Taylor — MARK TAYLOR
[Name, Title] EMD 12/02/19
[Town or Agency] ERAU Cowan
[Date]

BENJAMIN CAETANS-OLESON
[Name, Title] EMD 12/2/19
[Town or Agency] LANCASTER
[Date]

Scott M. Champagne
[Name, Title] Town of Lisbon, NH
[Town or Agency] EMD
12-9-19
[Date]

12 Record of Distribution

The RPHEA is distributed to partner agencies with defined roles and responsibilities for planning for, responding to, and recovering from public health emergencies. Media requests for access to the RPHEA should be directed to the North Country PHN. The following partner agencies have received the RPHEA, acknowledge their response roles, and documented the location where the plan will be kept.

March 2020 – Updated RPHEA will be distributed to all partner agencies; to be reviewed by RCC on an annual basis

Table 25: Record of Distribution

Name/Title/Agency	Plan Format	Date
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]
[Insert Name, Title] [Insert Agency]	[Electronic/Paper]	[00/00/0000]

13 RECORD OF CHANGES

The RPHEA is reviewed annually by the regional coordinating committee. Modification to the RPHEA is tracked below by documenting the date, name of the person who modified the document, and a brief description of the change. The Record of Changes reflects any significant change made to the plans in the prior two years.

Table 26: Record of Changes

Change #	Date	Name	Description of Modification
01	3/6/20 (in response to COVID-19)	Nicole Woods, April Mottram, Nancy Frank	Updated closed and open PODs; updated contact names and contact information; no significant change in plan
02			
03			
04			
05			
06			
07			
08			
09			
10			